ChrisB Therapy

Chris Bedard, LMFT, Sole Proprietor

New Client Intake Form Date: _____

Client Name: _____Home Phone: _____

Address: _____ City: _____ State: ____ Zip: _____ Date of Birth:

_____/_____/_____ Ethnicity/Race: _____ Gender: M__ or F__

Client Age: _____ School Grade (if applicable):_____

Parent/Guardian's Name (if client is less than 18 years of age): _____

Spouse's Name (if married): _____

Adult Client/Parent Information Below:

Marital Status: H**ow Long:**

1. ____ Single _____
2. ____ Engaged _____
3. ____ Married _____
4. ____ Separated _____
5. ____ Divorced _____
6. ____ Remarried _____
7. ____ Widowed _____

Employment Status:

1. Employed full-time
2. Employed Part time
3. Unemployed
4. Full-Time Homemaker
5. Retired
6. Full-Time Student
7. Part-Time Student
8. Other_____

Place of Employment: _____ Occupation: _____

Work Number: _____ Cell Phone Number: _____

May we leave a "call back" message **at your home**? Y__ N__ **At your work**? Y__ N__
May we leave a "call back" message at your cell phone number? Y ___ N ____

May we contact you via mail at the home/work address given above? Y__ N__

If you would like to be contacted by email instead please provide your email address: _____

Church / Religious affiliation: _____

In case of emergency, please notify (include address & phone number):

_____

Please List All Household Members

Name:	Age:	D.O.B.	Relationship:
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____

Medical History

Currently under Doctor's care: Yes ___ No ___

Doctors involved in your care/child's care (use reverse side if necessary): _____

_____

Health Problems (include allergies): _____

Medication currently used: NONE ___

Medication	Dosage	Prescribing Doctor	Reason prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Hospitalizations:

Date(s)	Reason(s)	Hospital _
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Counseling, Psychiatric Services or Chemical Dependency Services

Yes __ No __

Counselor/Facility Name _____

Date(s) _____

Reason(s) Helpful? _____

What is the highest level of education you (*the primary client or parent if client is younger than 18 years of age*) have completed? **(circle number)**

1. No formal education
2. Some grade school
3. Completed grade school
4. Some high school
5. Completed high school (Diploma or G.E.D.)
6. Some college
7. Completed college
8. 8. Some graduate work
9. A Master's degree
10. A Doctorate degree
11. Other Professional degree (J.D., M.D.)

What concerns bring you to counseling?

What changes do you want to see as a result of counseling?

Please circle ALL of the following items that are currently a concern to you regarding **YOU AND/OR YOUR PRESENT RELATIONSHIP**.

1. Premarital Counseling
2. Marital relationship
3. Remarried relationship
4. Poor communication
5. Sexual difficulties
1. 6. Parenting concerns
6. Anxiety
2. 8. Depression
9. Family relationships
10. Excessive alcohol/drug use
11. Stress
12. Self-esteem
13. Physical problem
14. Suicidal thoughts
15. Suicide Attempt
16. Incest
17. Childhood Emotional abuse
18. Childhood Physical abuse
19. Childhood Sexual abuse
20. Financial concerns
21. Anger
22. Grief/Loss

23. Work related concerns
24. Illness
25. Physical Abuse/Violence
26. Verbal Abuse/Violence
27. Eating Disorder
28. Cutting/Self-Mutilating Behaviors
29. Rape
30. Divorce Contemplation
3. 31. Divorce Recovery
31. Custody issues
32. Other (please describe)
_____
_____

Please circle ALL of the following items that are currently a concern to you regarding **YOUR CHILD OR CHILDREN (IF APPLICABLE)**.

____ NOT APPLICABLE

1. Stealing
2. Physical violence
3. Truancy
4. Adolescent pregnancy
5. Sexual abuse victim
6. Divorce adjustment
7. Anger
8. Peer relationships
9. Bedwetting/soiling
10. Issues with stepchildren/step-parenting
11. ADD/ADHD
12. Eating Disorder
13. Suicide Attempt
14. Poor communication
15. Fire setting
16. Drugs/alcohol
17. Sexual **abuser**
18. Physical abuse victim
19. Death/loss/grief
20. High anxiety
21. Poor self-esteem
22. Destructiveness
23. Disobedience
24. Depression
25. Cutting/self-harming behaviors
26. Other:
_____
_____

Please use the section below to list / describe the various strengths / positive attributes you, your spouse, your child, etc. possess:

_____

_____

_____

_____

_____

_____

How did you hear about Chris Bedard?

_____ Advertisement in Yellow Pages _____ Church _____ Friend _____ Psychology Today Listing

_____ Brochure _____ Doctor _____ Attorney _____ Other _____

May we send the person who referred you a "Thank You" for the referral? If yes, please provide the referring person's name and address below:

_____

_____

ABOUT OUR FEES

Chris Bedard strives to provide comprehensive, ethical and cost-effective mental health / behavioral health care for our clients. In order for us to continue this mission, we have instituted the following policy. **If you do not understand these policies, please ask our staff to explain before you are seen.**

*Usual and customary fees are $120.00 for a 55-minute counseling session. **Should a session last more than the usual 55-minutes, fees will be adjusted accordingly**.

*Phone consultations that last longer than 15 minutes are subject to half

I _____ understand that I am responsible for all charges at the time of my session. I consent to pay for these charges in a timely manner in accordance with office policy. I am also responsible for all charges incurred by the office in collecting on my account if my bill goes unpaid, including but not limited to collection agency fees, attorney fees, and court costs.

X _____ _____

Signature of client or parent / guardian Date

OTHER FEES AND SERVICES

Court Related Services

Court testimony costs begin at $250.00 an hour with a minimum charge of three hours. A retainer of $750.00 is **due one week prior** to the court date. Travel is billed at .50/mile. Failure to provide the specific fees as described constitutes a release from the requested court appearance.

It is required that a minimum of 36 hours' notice be given if the testimony is not required, otherwise the entire retainer is forfeited. If proper notice is given, the retainer will be refunded.

Additional services related to court preparation including all correspondence with attorneys or other service providers via phone, email or letter, documentation review and/or documentation preparation are also billed at $250.00 per hour, rounded to the nearest 15-minute increment.

In cases where a therapist is being contracted to work with a child in a divorce/custody case, a certified copy of the temporary orders or divorce decree must be provided prior to the therapist beginning treatment.

Payment is to be made at the conclusion of each session / group and all checks need to be made payable to: **Chris Bedard**. **Please note that there will be a $25.00 fee assessed for any returned check.**

I understand that my fee will be $ for each counseling session or $_____ for court related services. **(Please initial _____)**

Client Commitment to Counseling

I, _____ will make every effort to come for each counseling appointment. If it is necessary to cancel an appointment, I understand that this should be done at **least 24 hours in advance**. Should I fail to notify the counselor and miss an appointment, I understand that the usual fee will be assessed and that it will be my responsibility to pay for the missed session. Further, should I need to reschedule an appointment, I understand that fees will be assessed based on the following schedule regardless of whether insurance is being used:

24 hour notice (or more) *= no charge*
Less than 24 hour notice *= 35% of normal fee*
Less than 8 hour notice *= 65% of normal fee*
Failing to show for appointment without notification *= full fee*
X_____ _____

Signature of client or parent/guardian Date

Statement of Confidentiality

A. **Confidentiality:** Under Texas law, a counselor cannot guarantee confidentiality under the following circumstances:

1. There is suspected or witnessed child abuse or a belief that a child may be in imminent danger of abuse/maltreatment

2. There is suspected or witnessed elder abuse or a belief that an elderly person may be in imminent danger of abuse/maltreatment

3. There is suspected or witness abuse of a disabled person or a belief that a disabled person may be in danger of abuse/maltreatment

4. There is a threat of suicide / homicide, in which case the counselor may contact the appropriate authorities who can help prevent harm

5. In response to a properly issued subpoena from the court or order from a presiding judge.

6. There is a request from the State Licensing Agency for the client's records. In this event, those records shall be made available for the purpose of insuring professionalism.

B. **Except as noted in A above,** no information regarding a client shall be released without the prior written consent of the client or in the case of a minor, the written consent of the minor's parent/legal guardian.

I have read & understand the limits to confidentiality _____ (initial here)

Any suspected violations of counselor ethics may be reported in writing to the following governing agencies:

TX State Board of Examiners OR TX State Board of Examiners of Professional Counselors of Marriage & Family Therapists

Complaints Management and Investigative Section P.O. Box 141369 Austin, Texas 78714-1369

Disclosure Statement & Consent for Treatment

You have the right to competent, quality treatment that is consistent with professional standards established in practice and supported by research. Please be aware that the therapeutic process may involve personal awareness that may be emotionally painful, may cause heightened emotions, may cause anxiety, tension or stress and may cause some disruption or turmoil in your life as well as the lives of your significant others due to the subject matter being disclosed.

Counseling/therapy also has the potential to provide emotional support and stability for any family member involved in therapy. Further, it may relieve anxiety and create a safe environment for children or family members who are distressed. Finally, counseling/therapy has the potential for creating positive life changes in the form of long-term solutions to difficulties, and creating better communication. No guarantee can be offered for services as to results.

All communication with your therapist / counselor becomes part of the clinical record. Files are closed once the counseling relationship ends. Records for adult clients are destroyed seven years after the file is closed. Records for minor clients are destroyed seven years after the client turns 18 years of age. Records are the property of Chris Bedard's practice. If at any time in the future you would like to request a copy of your records, you will need to submit a written letter of request in which your therapist / counselor has up to 15 days to produce copies (at a cost of $.50/page) for you. For more information on records request, please see the Texas Health and Safety Code, Title 7, Subtitle E, Chapter 611.

All clinical records are stored and maintained according to HIPAA guidelines. As a consumer of mental health / behavioral health services, you have certain rights under HIPAA guidelines. By signing below, you are attesting to the fact that you have read and that you understand the HIPAA guidelines as outlined in the HIPAA notice posted on our website and/or in our office.

Finally, we do not provide 24-hour crisis stabilization services. If you experience a crisis, please contact 911 or immediately go to your nearest emergency room

I have read and understand all the above statements (**session / court fees**, **client commitment**, **limits to confidentiality** & **the disclosure statement**) and I / WE VOLUNTARILY CONSENT TO TREATMENT.

Signature of self/parent/legal guardian:

_____

Signature of spouse / witness: _____

Date: _____

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