Hill Country Counseling Associates, PLLC

COUNSELING FOR INDIVIDUALS, COUPLES & FAMILIES

Adolescent Psychotherapy Intake Form

Thank you for taking a few minutes to complete this form. The information you provide is confidential and will be very helpful for your counselor when meeting for the first time. You may submit your completed forms via email (info@hillcountryca.com), fax (210-978-5514) or bring them with you to your first session.

There is an adolescent and adult section in this Intake. You may complete and turn them in separately at the time of the first counseling session, if you'd prefer to maintain confidentiality between parent and child.

If you have any questions or concerns, please ask!

Adolescent completes this part:

Today's Date _____

Name _____ Age _____ Date of Birth _____

Address _____ City, State, Zip _____

School _____ Grade _____

Hobbies _____ Job _____

Who do you currently live with? _____

Do you believe in God? Yes___ No___ What is your religion? _____

What has brought you to counseling today?

_____

To help me better understand your situation, please complete the following checklist. Rank them according to the following:
1 = major problem **2** = sometimes a problem **3** = never a problem

___ Problems with my parents or other family members
___ Problems at school
___ Making friends/Getting along with friends
___ Feeling accepted by others
___ Trusting others
___ Dislike my appearance/body
___ Struggle with personal values
___ Depression
___ Worrying a lot; feeling anxious
___ Sexual feelings and/or problems
___ Eating issues – don't eat enough, eat too much, make self vomit to control weight
___ Dealing with alcohol/drug abuse (self or family member)
___ Can't decide on a career
___ Feeling that I'm not normal
___ Death of close friend, family member, pet, etc.

Is there anything else you'd like for me to know? Or is there something you want to further explain about one of the items above?

_____

_____

Do you have any medical conditions and/or medications you are currently taking?

_____

_____

Parent/Guardian completes the rest:

Phone number(s) where I may call/leave a message regarding your child's therapy:

Home Phone _____ Cell Phone _____ Work Phone _____

Email address where I may send information regarding your child's therapy: _____

Appointment Reminders:

- ☐ Please send via text to: _____
- ☐ I would prefer email reminders. Please send them to: _____

How did you hear about us?

- ☐ Psychology Today
- ☐ BRCC
- ☐ Theravive
- ☐ Friend/Coworker/Family
- ☐ Helotes Echo Newspaper
- ☐ Health Insurance Provider

Do you have any specific concerns or observations that you'd like to share regarding your child?

_____

_____

What issue(s) would you like to have addressed in counseling? What outcome are you hoping for?

_____

_____

Others living in the home with your child, including adults and children:

Name		Age	Sex	Relationship	Problems or comments
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____

Child's Mom:

Highest level of education: _____ Occupation _____

Child's Dad:

Highest level of education: _____ Occupation _____

What is your religious background/involvement? _____

Please check all that apply and provide a brief explanation:
Family history of…

___ Alcoholism _____

___ Mental Illness _____

___ Substance Abuse _____

___ Other conditions I should know about _____

Has your child had psychiatric care or counseling before? ___ No ___ Yes

If so, please provide name of clinician and dates below:

_____

_____

What issue(s) would you like to address in counseling? What outcome are you hoping for?

_____

_____

In the unlikely event of an emergency, is there someone we have your permission to contact?

Name: _____ Relationship: _____

Phone: Home (_____) _____ Cell (____) _____ Work (____) _____

Insurance Information

Insurance may reimburse all or part of counseling fees. **Hill Country Counseling Associates, PLLC** files insurance for those providers with whom she has been credentialed as a contracted provider. Please contact your insurance company to inquire about mental health benefits. For those who prefer to pay up front, **Hill Country Counseling Associates, PLLC** will provide you with a "superbill" that may be submitted to your insurance provider for reimbursement. (If your insurance provider requires a different form, we'll be happy to complete whatever form is required.)

Please note: Payment for services is the responsibility of the client, regardless of whether or not charges are covered by private insurance.

Please bring a copy of your ID card (front and back) to your first counseling session, and to any subsequent appointment, if your insurance provider should change. Complete the information below using your ID card.

If you are not aware if you have a copay, deductible, etc., contact your insurance provider for this information, as it is a requirement at your first visit. This is not set by Hill Country Counseling Associates, PLLC, nor is it the same for all clients with the same insurance provider. Your insurance company, and specific plan, will determine your benefits.

Primary Insurance Company _____

Address _____

Policyholder_____ Policyholder's date of birth: _____

Client's relationship to policyholder _____ Policy ID Number _____

Group Number _____ Payer ID _____

Copay: _____ Deductible: _____ Has deductible been met? _____

Secondary Insurance Company _____

Address _____

Policyholder_____ Policyholder's date of birth: _____

Client's relationship to policyholder _____ Policy ID Number _____

Group Number _____ Payer ID _____

Copay: _____ Deductible: _____ Has deductible been met? _____

ASSIGNMENT OF BENEFITS:

Your signature is required for processing insurance claims and ensuring payment for services rendered.

I authorize release of all information necessary to process my insurance claims and relative to my care. I understand that I am financially responsible for all charges. I have read and understand this information; any questions have been satisfactorily answered.

Client name (print): _____ Client signature: _____

Date: _____

Revised March 19, 2015

No-Show and Cancellation Agreement

Revised 3/19/15

In an effort to provide excellent client service to all of our clients, and to provide the best possible therapeutic environment, it is our policy to require a fee for no-show appointments and cancellations made less than 24 hours in advance of the scheduled appointment.*

The fee of $95.00 will be charged to the following credit card:

____Visa ____MasterCard ____American Express ____ Discover ____ HSA

Credit Card #: _____

Expiration Date: _____ CCV (Credit Card Verification)** _____
**CCV is the last 3 digits on the back of your card – or the 4 on the front of your American Express.

Name as it appears on Card: _____

I, _____, understand and agree that if I do not show

up for my scheduled appointment or if I cancel my scheduled appointment with less than 24 hours

notice, the above named credit card will be charged in the amount of $95.00.

Signature_____ **Date** _____

Printed Name _____

Address: _____ Daytime Ph.: _____

City: _____ Zip: _____

Email address where receipt should be sent: _____

**Exceptions for emergencies are determined by your counselor.*

Adult's Consent to Treat Minor

Name of Parent or Guardian: _____

Name of Minor Child Receiving Counseling: _____

Minor Child's Age: _____ Date of Birth: _____

Name of Counselor: _____

It is necessary to protect confidentiality with minors during the counseling process because they will not be honest with their counselor if they feel their parents will know everything that was discussed. In that scenario, they would only tell their counselor as much as they would tell their parent, so there's really no point taking them to counseling. For this reason, we give the same level of respect and confidentiality to minors as we do adults. This does not mean that the counselor will not brief parents on the counseling process, and progress. However, they will only share information that is acceptable to the minor client. In the event that something is discussed that we feel the parent needs to know, we will explain to our client why their parent should know and offer to share that information in their presence or on their behalf.

This is to certify that I give permission to **Hill Country Counseling Associates, PLLC** to treat my minor child with individual counseling and/or family therapy. I understand that part of that may include referral to other professionals for further evaluation/testing, when necessary. I hereby waive my parental right to obtain information from, and copies of any medical records maintained by, **Hill Country Counseling Associates, PLLC** regarding the evaluation and treatment of my child, _____, age _____. I understand that **Hill Country Counseling Associates, PLLC** may refuse to provide me, or any third party acting on my behalf, with information and records pertaining to this child's mental health evaluation and treatment. I hereby release **Hill Country Counseling Associates, PLLC** from any and all liability for good-faith refusal to disclose the child's information or records.

By signing below, I also acknowledge that I have every legal right to seek counseling services for the above-listed child, as there is no legal documentation in existence that states that I require approval from the child's other legal parent/guardian. If there *is* legal documentation pertaining to such, regardless of whether or not it allows or prohibits my seeking counseling services for my child, I am submitting a copy of that legal order, modification, etc., with this Intake paperwork. I understand that if I am required to secure the permission of my child's other legal parent/guardian, s/he will also sign a copy of this consent form or my child will not receive counseling services from **Hill Country Counseling Associates, PLLC**.

Signature of Parent/Guardian _____ Date _____

Street Address _____

City/State/Zip _____

Home Phone _____Work Phone _____

Revised March 19, 2015

Hill Country Counseling Associates, PLLC Client Rights and Responsibilities

METHOD OF TREATMENT

Counseling methods are generally solution-focused and cognitive-behavioral; however, treatment is eclectic, as it is dependent upon the strengths and weaknesses of each client. Where appropriate, biblical principles are woven into the therapeutic process, if welcomed by the client. **Hill Country Counseling Associates, PLLC** possesses a positive approach to therapy, as it is the belief that although everyone goes through difficult seasons in life, we are all empowered to learn from those experiences and make the necessary changes to adapt and move forward.

GOALS, RISKS & BENEFITS

Emotional side effects from counseling are inevitable. It can be very difficult processing painful memories and situations; therefore, symptoms may get worse before they get better. The role of **Hill Country Counseling Associates, PLLC**, is to assist clients in confronting those issues and emotions and working through them, together, over time.

LENGTH OF TREATMENT

The length of treatment varies, as it is dependent upon a number of variables, including the severity of presenting issue(s), time required for processing, homework completion, degree of resistance, success in behavior modification, etc. Each individual possesses unique strengths and limitations, which will significantly impact progress. Often, other types of counseling or education may be recommended to a client, such as a therapy/support groups, anger management class, etc. The overarching goal is to complete counseling as effectively as possible and in a timely manner.

FEES

The client and counselor decide together how often they will meet and for how long. Counseling sessions will be 60 minutes and the only charge at that time will be the copay, unless your deductible hasn't been met. Personal checks, cash and credit cards are accepted. Payment is due in full at the beginning of each session and *clients can be charged, if necessary, for any missed/unpaid sessions with any credit card(s) on file*. There is a charge of $30 for each returned check and $5 late payment fee for payments not made in session. Balances that have not been paid will accrue late fees in the amount of $10 per month. After 30 days, collection services are enlisted by an independent HIPAA-compliant agency and an additional collection fee of $35 is added to the outstanding balance.

Insurance may reimburse all or part of counseling fees. **Hill Country Counseling Associates, PLLC** files insurance for those providers with whom they have been credentialed as an in-network or contracted provider. Please contact your insurance company directly to inquire about coverage. For those who use an insurance provider who is out-of-network, you will be required to pay the cost of the session up front and **Hill Country Counseling Associates, PLLC** will provide you with a "superbill" that may be submitted to your insurance provider for reimbursement. Please be advised that eCounseling (including email and phone) is seldom covered by insurance. Payment for services is the responsibility of the client, regardless of whether or not charges are covered by private insurance.

All fees incurred for lost time/wages because of court hearings, subpoenas served, or other legal matters regarding client(s) business, will be paid in a timely manner using the credit card on file. The client's signature below authorizes this transaction. Wages to be paid will consist of $150/hr minimum, including travel time and excluding mileage. If out of town travel is required, all associated costs for airfare, lodging, rental car, etc., will be required, in addition to the minimum hourly wages. A $600 non-refundable retainer must be paid, in advance. Your signature below also waives involvement of **Hill Country Counseling Associates, PLLC**, in any legal matters if it is deemed inappropriate to participate. **Hill Country Counseling Associates, PLLC**, does not guarantee that testimony will be in favor of a client who subpoenas or court-orders us to testify on their behalf.

Treatment summaries provided to employers, disability insurance companies, schools, courts, attorneys, other medical professionals, etc., will incur a $35 charge.

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Please keep your receipts in a safe place for insurance and/or tax purposes. While we are happy to be of assistance to you in providing copies of receipts, this is a time-consuming process so we charge a $10 fee for this service.

CANCELLATIONS

In the event the client is unable to keep an appointment, notification is required at least 24 hours in advance, business days only. The client is required to pay for any missed sessions (with the credit card on file) unless s/he calls 24 hours in advance to cancel the appointment. An exception may be made if **Hill Country Counseling Associates, PLLC** deems the situation an emergency.

RIGHT TO PRIVACY/CONFIDENTIALITY

All communication between the client and counselor becomes part of the clinical record, and is the property of **Hill Country Counseling Associates, PLLC**, in accordance with legal requirements. Adult client records are disposed of seven years following their last appointment and minor client records are disposed of seven years following the client's 18th birthday.

By default, communication between a client and counselor is confidential; however, there are exceptions to this, including the following:

- The counselor determines the client is a danger to himself or someone else;
- The client discloses abuse, neglect or exploitation of a child, elderly or disabled person;
- The client authorizes the counselor to release records;
- The counselor is ordered by a court (including subpoenas) to disclose information; and/or
- The counselor is otherwise required by law to disclose information.

EMERGENCIES

During office hours, the client can contact the counselor at **210-838-5514**. If the client is unable to reach their counselor in a timely manner, s/he should contact their physician, a local emergency room or the local police department, when necessary and appropriate. It is the client's responsibility to seek the appropriate resources in emergency situations.

My signature below indicates that I have read and understand the Client Rights and Responsibilities and any questions about these policies have been answered to my satisfaction. Moreover, a copy of these policies has been provided to me for my records.

By your counselor's signature, **Hill Country Counseling Associates, PLLC** verifies that this statement is accurate and acknowledges commitment to conform to its specifications.

Client or Guardian Signature: _____ Printed Name: _____ Date: _____

Counselor Signature: _____ Printed Name: _____ Date: _____

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