NEW CLIENT INFORMATION SHEET – for minor clients

Thank you for choosing **Elledge Counseling Associates** for your counseling needs. The following pages contain:

- Information on fees and counselor experience
- Intake and policy forms
- HIPPA forms
- Addresses and tips on finding the counseling offices

Please complete a set of intake and policy forms for each child who will be a client and bring them with you to your first appointment.

If you are divorced, we will also need a copy of the most recent divorce decree documenting your right to seek counseling for your child(ren) before we can proceed with the appointment.

If you have any questions, prior to your appointment, please feel free to call your assigned counselor. Again, thank you for choosing **Elledge Counseling Associates**. We look forward to meeting with you soon.

FEE SCALE AND COUNSELOR EXPERIENCE

Fee Scale

The fees for a 45-minute counseling session range in price from $25-$100 and are based on each counselor's education, experience, and office location.

Counselor Experience

Licensed Professional Counselor (LPC) - an individual in the state of Texas who has completed a master's degree in psychology or counseling, passed the state exam, and completed 3,000 postgraduate hours of supervised counseling experience with clients.

Licensed Professional Counselor Intern (LPC Intern) – an individual in the state of Texas who has completed a master's degree in counseling or psychology, passed the state exam, and is currently working on the required 3,000 postgraduate hours of counseling experience with clients.

Graduate Student – an individual who is at the end of their master's degree program in counseling or psychology and is working on the required hours of supervised counseling experience to complete their graduate degree. They are under the direct supervision of their university professor and the director of ECA.

FEE ACCOUNTABILITY AND FINANCIAL CONSENT STATEMENT

I am aware that I must cancel an appointment at least 24 hours before the scheduled appointment to avoid full financial responsibility for that session. It is my responsibility to call or text my counselor (day/night/weekend) to cancel my appointment.

I agree to the one-time charge or debit to my credit/debit card in the amount of my regular appointment fee following any missed session or appointment cancelled with less than 24 hours' notice. Elledge Counseling Associates is not required to notify me of this charge.

I am aware that payment is due at the beginning of each session. All checks should be made out to **ECA**. If paying by cash, I will bring the exact amount. Counselors are unable to make change and the excess will be applied to my next session. I understand that if I choose to pay ahead for sessions, no refunds will be made for unused sessions.

If my check is returned for insufficient funds I agree to a one-time credit/debit charge to my card/account plus the NSF fee and a service charge. Elledge Counseling Associates is not required to notify me of this charge.

If I do not return books/CD/DVD material(s) to my ECA counselor, I agree to the one-time charge or debit to my credit card/account in the amount of the replacement cost of the material(s) and credit card service fee. Elledge Counseling Associates is not required to notify me of this charge.

I understand that my counselor is unable to make further appointments with me until any balance on my account is paid in full.

Credit /Debit Card Information:

Name as it appears on the card _____

Credit/Debit Card #_____

Expiration Date_____ Security Code _____

Cardholder's Zip Code _____

List all client's names this card may be used for to make payment:

_____ _____ _____

_____ _____

Cardholder Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY.

We are required by The Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by the practice, and of your individual rights and the practice's legal duties with respect to confidential information.

Ways in Which We May Use and Disclose your Protected Health Information:

We may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment and healthcare operations.

- **Treatment** means providing, coordinating, or managing mental health care and related services. *For example* – use or disclosure by the health care provider in training programs in which "students, trainees, or practitioners in mental health" learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.

- **Payment** means activities such as obtaining payment for the mental health care services we provide for you either from your insurance or another third-party payer. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, and procedures performed.

- **Health care operations** include the business aspects of running our practice. *For example* – to evaluate our treatment and services, or to evaluate our staff's performance while caring for you.

We may contact you to provide appointment reminders or other services that may be of interest to you. We will disclose your protected health information to any person *you identify* that is involved in your care or payment for your care. For example - a family member, relative, close friend, a pastor or pastor's representative whom you have asked us to communicate with.

We will use and disclose your protected health information *when required to by federal, state, or local law*. There are certain situations in which, as a therapist, I am required by ethical standards to reveal information obtained during therapy to other persons or agencies - even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or are ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke an authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate you understand our operational use of your information for treatment, payment and healthcare operations as stated above.

_____ _____

Printed Name of Client Date

_____

Signature of Parent/Guardian/Responsible Party

NOTICE OF PRIVACY PRACTICES CON'T

Your Health Information Rights:

Although your records are the physical property of **Elledge Counseling Associates**, the information belongs to you. You have the following rights with respect to your information, which you can exercise by presenting a written request to our office manager.

You have:

- The right to request restrictions on certain uses and disclosures of your information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. For example – a request that we not identify the agency when we contact you. (i.e.- "This is **Elledge Counseling Associates** calling")
- The right to inspect and copy the information that we maintain about you. However, we ***may deny an individual access***, provided that the individual is given a right to have such denials reviewed, in the following circumstances:
    - a health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to ***endanger the life or physical safety of the individual or another person***;
    - the information makes ***reference to another person*** (unless the other person is a health care provider) and the health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
    - The request for access is made by the individual's personal representative and the health care provider has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to ***cause substantial harm to the individual or another person***.
    - If you wish to inspect or copy your information, you must submit your request in writing to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.
- The right to billing records.
- The right to revoke your consent to release information except to the extent that the agency has taken actions in reliance on the previously signed consent form.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. For example – at your regularly scheduled appointment at a church satellite office, or by e-mail or fax.
- The right to amend your information if you feel that it is incomplete or inaccurate. You must make this request in writing to your therapist stating exactly what information is incomplete or inaccurate and your reasoning to support your request. We will respond to your request with in sixty (60) days. In rare cases your request may be denied. For a complete description of Rights of Amendment, please contact our office manager.
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request.
- The right to file a complaint if you believe we have violated your medical information privacy rights. You have the right to file a written complaint to our office manager, or Executive Director, or directly to the Secretary of Health and Human Services

To file a complaint with our practice, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Brenda Elledge, Director, **Elledge Counseling Associates 328 Pebblebrook**, Red Oak, TX 75154. You should know there will be no retaliation for your filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. If and when one is available, you may request a written copy of a revised notice from this office.

REQUEST TO PARTICIPATE IN COURT PROCEDEINGS

If I or my legal counsel requests or subpoenas any counselor from ECA **t**o appear on my behalf, in a deposition or in court, I agree to pay that counselor for his or her time and expenses. Billable time will be compensated at the counselor's regular session fee rate per hour.

Billable time and expenses include:

1. Time spent by the counselor reviewing the case files and preparing for court testimony.
2. The drive time to and from the counseling office and the place of testimony.
3. Time spent waiting for their court appearance and testimony.
4. Any tolls, hotel or meal costs associated with the court appearance.

If I or my legal counsel requests or subpoenas treatment summaries or session attendance documentation on my behalf, I agree to pay my counselor's regular session fee per hour to research, copy and or complete requested materials. This includes information for all legal, disability or insurance purposes. Clients may pick up the documents or pay to have the documents mailed to them. All payments must be processed before the documents are presented.

ECA counselors do not give legal advice so we strongly urge all clients to discuss with their lawyers the perceived need for a counselor's documentation, court testimony etc. and the subsequent financial burden it may cause to the client.

By signing below, you are stating that you have read and understood this policy statement and have had any questions about the policies and this document answered to your satisfaction.

Client Printed Name _____ Date _____

Client Signature _____

INFORMED CONSENT AND ECA POLICIES

I consent to my child taking part in treatment with an **Elledge Counseling Associates (ECA)** counselor. I understand that the counselor will develop a treatment plan consisting of goals I have for my child, goals my child may have and those the counselor determines are in the best interest of my child.

I understand that no promises have been made to me as to the results of treatment.

I am aware that I may stop treatment at any time, however, I agree to talk with the counselor if I feel like ending therapy before all the treatment goals for my child are met.

Sessions last for 45 minutes. I also understand that if I or my child is late to an appointment the counselor will not run over into another client's appointment time and I will be billed for the entire session.

In the case of an emergency I may call my child's counselor. If the counselor is unavailable and it is a life-threatening emergency, I will call 911 or take my child to the nearest emergency room.

Confidentiality is the ethical right of all clients. However, there are certain exceptions, which surpass the confidentiality of the client-therapist relationship and the therapist may be ethically bound and legally required to inform the proper authorities.

Exceptions to Confidentiality:

1. The therapist makes an assesses that the client is a danger to self or others.
2. A client reports past or present abuse/neglect/exploitation of a child, elderly person, or mentally challenged person
3. A client acknowledges committing past or present abuse/neglect/exploitation of a child, elderly person, or mentally challenged person.
4. When counseling records are subpoenaed by a court of law.
5. The client shares with the counselor their use of pornography involving minors.

By signing below, you are stating that you have read and understood this informed consent and policy statement and have had any questions about this document answered to your satisfaction.

_____ _____

Client Printed Name Date

_____

Parent/Guardian Signature

LIMITS OF THE COUNSELING RELATIONSHIP

It's important to remember that although the sessions with your counselor may feel very intimate emotionally or psychologically, the counseling relationship is a professional one and not a social one.

The counseling relationship is governed by certain laws and ethics that are set in place for your protection as a client.

For example:

1. Contact must be limited to sessions you schedule with your counselor.

2. Due to ethical guidelines, you are asked not to invite your counselor to social gatherings, offer gifts, ask your counselor to write references for you or relate to you in any way other than the professional context of the counseling sessions (this includes any interaction involving social networking sites).

3. Your counselor is required to keep the identity of clients confidential. Therefore, your counselor cannot and will not acknowledge you outside of counseling sessions unless you first acknowledge them.

4. When the counseling relationship ends, the limitations of contact with your counselor must remain the same.

My signature below affirms that I have read and understand the limits of the counseling relationship.

_____ _____

Client Printed Name Date

_____

Parent/Guardian Signature

Parent/Guardian Participation Agreement

Parents are the most important people in a child's life. We as counselors are here to support your child by providing a safe environment for him/her to process difficult emotions, thoughts and experiences. We will educate him/her on certain topics or provide coping tools and tips as appropriate. At times we will also be advocates for your child and ask you to work with us to see the improvement you and/or your child desire.

Some parent's mistakenly think that they will bring their child in for a 45-minute session every week or every other week and the counselor will work a miracle and solve all the problems their child has in two months. Unfortunately, that is unrealistic and allowing you or you child to believe that sets you both up for disappointment.

So, in order to set you both up for success, here's what we ask of you:

1. Regular, consistent and punctual attendance at appointments (weekly is best whenever possible)
2. Participation in educational and encouraging resources (fancy words for the homework that your child's counselor will assign you – articles, videos, activities, books, podcasts)
3. Patience (your child's problems probably didn't develop in a few weeks/months so understanding that solving them in that short of time probably won't happen, either)
4. Attend regular parent meetings with your child's counselor to discuss progress, setbacks and treatment goals
    - Parent sessions are open to both parents unless deemed otherwise by a judge.
    - Separate sessions for divorced parents are the norm.
    - Stepparents are welcomed into sessions with their spouses.
    - Grandparents are welcome to attend parent sessions if invited by the child's parent/guardian.

_____ I understand that participation in my child's therapy is essential to the best outcome.

_____ I am willing to follow the participation guidelines outlined above.

_____ _____

Client Printed Name Date

_____

Signature of Parent/Guardian

RIGHT TO SEEK COUNSELING FOR A MINOR

Please initial the statement that describes your legal right to seek counseling for the minor child named below.

_____ I am the child's **biological /adoptive parent** with full rights to seek counseling for my child.

_____ I am the child's **legal guardian** and have provided the necessary legal paperwork as proof.

_____ I am **appointed by the court or CPS** with rights to seek counseling for the child and have provided legal paperwork as proof.

If legal documentation required:

_____ I have provided legal documentation that I have the right to seek counseling for the minor child without joint consent by the child's other legal parent.

_____ I have provided the counselor with the most recent legal documentation of my rights to seek counseling for the minor child.

_____ _____

Client Printed Name Date

_____ _____

Parent/Guardian Printed Name Signature

UNACCOMPANIED MINORS POLICY

For the protection of all children and in agreement with our partner sites:

Please initial each policy and sign at the bottom acknowledging your understanding of this policy.

_____ Minors are not allowed to be unaccompanied in the office buildings for any reason.

_____ Minors are not allowed to wait unsupervised while their parent(s) are in session.

_____ Minor clients waiting for their session must be accompanied by a parent/guardian at all times.

_____ Minor clients age 10 years and under must have a parent or guardian remain in the building during their session.

_____ Parents of minor clients age 11 or older may leave the premises during their child's appointment but if they do, must return to the office by quarter after. Parents who are late picking up children from appointments may be charged a late fee equivalent to their session fee and may no longer be able to schedule appointments.

_____ Minor clients who drive themselves to session may remain unaccompanied while waiting on their counselor.

_____ _____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature

Elledge Counseling Associates

Confidential Child Intake Information

Date _____

The purpose of this form is to obtain a comprehensive picture of your child's current circumstances. Answering these questions as fully and accurately as possible will facilitate the initial evaluation and make better use of our time. If there are questions on this form that you do not wish to answer, feel free to leave them blank.

Child's Name:_____ **Age**:_____ **Date of Birth**:_____
Gender: □M□F

Does child have a preferred name/nickname/pronoun? _____

Name of person filling out this form: _____

Relationship to child: _____ Your cell number: _____

Your email: _____

Address where child lives: _____

City/State/Zip: _____

What is your relationship status? (please circle)
single divorced separated widowed married relationship remarried

What is their relationship status? (please circle)
single divorced separated widowed married relationship remarried

Mother's Name: _____ Cell number: _____

Mother's email: _____

Mother's address: _____ City/State/Zip: _____

Father's Name: _____ Cell number: _____

Father's email: _____

Father's address: _____ City/State/Zip: _____

If parents are separated or divorced:

Non- custodial parent name: _____ Gender: □M□F

Address: _____ City/State/Zip: _____

What is the custody/visitation arrangement? _____

May we contact by phone? _____ **Yes** _____ **No**

May we contact by text? _____ **Yes** _____ **No**

May we contact by email? _____ **Yes** _____ **No**

I understand that communication by voicemail, text or email cannot be guaranteed private communication. I accept the risks to confidentiality when using such methods of communication.
_____ Yes _____ No

Family Make-Up

Please list the child's siblings:

1.	***Age:***	***Step:*** ☐yes no	***Adopted?*** ☐yes no	***Gender:*** ☐male female
2.	***Age:***	***Step:*** ☐yes no	***Adopted?*** ☐yes no	***Gender:*** ☐male female
3.	***Age:***	***Step:*** ☐yes no	***Adopted?*** ☐yes no	***Gender:*** ☐male female
4.	***Age:***	***Step:*** ☐yes no	***Adopted?*** ☐yes no	***Gender:*** ☐male female
5.	***Age:***	***Step:*** ☐yes no	***Adopted?*** ☐yes no	***Gender:*** ☐male female

Of which siblings/step-siblings does the child primarily live with and have contact with?

_____
_____
_____

Parent Participation

Are both parents aware of this counseling appointment? ☐yes no

If no, please explain: _____

Are both parents willing to be involved in therapy as deemed necessary? ☐yes no

If no, please explain: _____

Spiritual or Cultural Information

It is our desire to understand your child and/or family as much as possible to better serve you. If there is any information about your family or the child's religion or culture that would be important for us to know or understand please include that information here:

_____
_____
_____
_____

LIFE FUNCTIONING INVENTORY

Client Name _____DOB /Age_____

Please list the problem(s) with which you want help:_____
_____
_____
_____

How long has this been a problem? _____

Has your child had previous counseling or other psychological treatment(s)? □yes no If yes, where and when was this received? For what problems? Was this a good or bad experience?
_____
_____
_____
_____

What strategies have been used at home to address these problems?

verbal reprimands	avoiding the child	removal of privileges
time-out	yelling	giving in
physical punishment	rewards	communication

Over which of the following issues (if any) do you have regular conflict?

room cleaning	dating relationships	choice of friends
curfew	household chores	church attendance
music	clothes/appearance	other _____

Do you consider yourself (and your spouse) consistent in your disciplining?

most of the time	some of the time	none of the time

Do you and your spouse have any consistent differences in your approach to discipline or expectations of your child?
□yes no □n/a

Family Information:

Please list any previous mental health history of any family members:
_____
_____
_____
_____

Briefly describe your child's relationship with other members of your household:
_____
_____
_____
_____
_____

Medical History:

Has your child had any of the following:

head injury what age? _____ loss of consciousness? □yes no

surgery for what?
_____

broke bones describe:
_____

severe injury describe:
_____

medications list:
_____

Is your child having any difficulty with appetite or eating habits? ☐yes □ no
If yes, check where applicable:
□ eating less □ eating more □ binge eating ☐restricting calories □ significant weight change (in past 2 months)

Has your child ever been hospitalized for psychiatric reasons? ☐yes ☐no
If yes, please specify the following: Reason for hospitalization:
_____
Hospital location: _____
Dates of hospitalization: _____
Duration of hospitalization: _____

Has your child had suicidal thoughts recently? ☐yes ☐no If yes, how often? ☐daily weekly ☐monthly ☐rarely
Have they had them in the past? ☐yes ☐no If yes, how often? ☐daily ☐weekly ☐monthly ☐rarely

Has your child ever intentionally inflicted harm upon themselves? ☐yes ☐no
If yes, how often? ☐daily ☐weekly ☐monthly ☐rarely
Nature of harm:
_____
_____

Academic History:

School currently attending: _____ Grade: _____
Grades (check all that apply):

Most recent report card:	___A's	___B's	___C's	___D's	___F's
Typical grade performance:	___A's	___B's	___C's	___D's	___F's

Has your child ever had an individual, educational assessment? □yes no
If yes, where, when, and what were the results?
_____
_____

Has your child ever been held back a grade? ☐yes ☐no If yes, what grade? _____ Reason? _____

Check any of the following learning problems that have been identified:

ADD/ADHD	Dyslexia	Reading Disorder
Math Disorder	Written Expression Disorder	Other: _____

How easily does he/she make friends?
better than average average worse than average

Does your child have a best friend? □yes no Friends how long? _____
On average, how long does your child keep friendships?
less than six months one year more than a year

Miscellaneous:
Please list any major changes in your child's life over the past five years:
_____
_____
_____

Is there anything else you want me to know about your child?
_____
_____
_____

Please list a few positive traits and strengths of your child:
_____
_____
_____

Questions:
Please list any questions you have that you want to remember to ask your counselor about during the intake appointment.
_____
_____
_____
_____

Thank you for completing this paperwork. I look forward to meeting you and your child.

DIRECTIONS TO OUR LOCATIONS

Red Oak 320 E. Ovilla Rd., Red Oak, TX 75154
We are located in the offices of First Baptist Red Oak. A brick electronic sign will mark the entrance to the FBRO campus and the church offices are located to the side of the sanctuary building. You may use the office parking lot and either wait on the front steps or in your car. Your counselor will be with you as soon as possible.

Waxahachie 210 YMCA Dr., Waxahachie, TX 75165
We are located in The Avenue church offices (not the sanctuary). From Hwy 77/Ferris Avenue turn west onto YMCA drive and follow it to the **dead end**. The church office building will be on the right. Please ring the buzzer to the right of the front door and your counselor will be with you as soon as possible.

Ferris 304 W 5th St., Ferris, TX 75125
We office inside the First Baptist Ferris/CenterPoint church. To reach the church offices you will **enter under the awning**. You may wait outside by the door or in your car and your counselor will come for you as soon as possible.

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Ennis 1200 Country Club Rd., Ennis, TX 75119
We office inside Tabernacle Baptist Church. Upon entering the parking lots look for the covered driveway entrance. Park there and you may wait outside by the door or in your car and your counselor will come for you as soon as possible.

Duncanville 227 W. Center St., D'ville, TX, 75116
Our offices are in a white house with a red door, surrounded with a large porch and big trees. A sign in the yard will say, "Project Duncanville." The door may be locked if your counselor is with another client. You may wait outside by the door or in your car and your counselor will come for you as soon as possible.

Desoto 50 W. Pleasant Run Rd., Desoto, TX 75115
We office inside Windsor Park Baptist Church. Park in the front left parking lot and enter through the doors by the "Office" sign. If the entrance is locked, ring the doorbell on the right side of the door and someone will open the door for you.

Mansfield 2271 Matlock Rd., Mansfield, TX 76063
Our offices are located within Living Church. Your counselor will give you specific directions for entry

Mesquite 2600 Eastglen Blvd. Mesquite, Tx 75181

The counseling offices are located within New Community Church. Your counselor will give you specific directions for entry

Arlington 5950 S Collins St, Arlington, TX 76018
We office inside The Grace Place Church offices. Your counselor will give you specific directions for entry.