TREE OF LIFE COUNSELING CENTER

151 North Town Crossing Suite 100 Waxahachie, TX 75165 (469) 552-6610

NEW CLIENT INFORMATION (MINORS) DATE: _____

NAME _____ NICKNAME: _____

ADDRESS _____ CITY _____ ZIP _____

AGE _____ BIRTH DATE _____ SCHOOL CHILD ATTENDS _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian 1: Name _____ Age _____

Occupation _____ Education _____

Phone: _____ Email: _____

Parent/Guardian 2: Name _____ Age _____

Occupation _____ Education _____

Phone: _____ Email: _____

Preferred method of contact (check) Phone __ Email __ Text __ May I leave a message on phone? _____

Siblings: Name _____ age _____ full step half (circle)

Name _____ age _____ full step half

Name _____ age _____ full step half

Name _____ age _____ full step half

Name _____ age _____ full step half

FAMILY DYNAMICS

Are both parents living? _____ Are both parents present in child's life? _____

If no, please explain: _____

Parents are (please check all that apply): If separated/divorced, how old was the child when this occurred? _____

Married	Separated	Divorced	Never Married	Living Apart	Living Together	Other

If parents are divorced/separated (please check all that apply):

Mother is remarried	Father is remarried	Mother is single	Father is single	Mother is in a relationship	Father is in a relationship

Who all lives in the home with the child? _____

How do child's parents get along? _____

If parents are not together, who has physical custody?_____ Who has legal custody? _____

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If divorced, do you have the right to consent to psychological treatment for your child? _____

Please note that the state of TX requires us to have the most recent custody agreement on file before counseling can commence.

FAMILY MENTAL HEALTH HISTORY

If any apply, please indicate for the child or relative of the child (i.e., father, mother, sibling, grandparent)

Depression			
Anxiety Disorder			
Eating Disorder			
Alcohol/Drug Addiction			
Schizophrenia			
Sexual Abuse			
Suicide/Suicidal Ideation			
ADD/ADHD			
Autism Spectrum Disorder			
Developmental Delays			
Other (Please list)			

HEALTH HISTORY

Please describe your child's general health. _____

Please note any serious accidents, illnesses or injuries. _____

List any medications that your child currently takes and dosage: _____

_____

Any prior hospitalizations (date. reason, treatment) _____

Name of Primary Care Physician: _____ Date of last exam: _____

Name of Psychiatrist (if applicable): _____ Date of last visit: _____

SOCIAL HISTORY

Check all that describe your child socially:

He/She prefers to play alone		He/She prefers to play with others	
My child makes friends easily		My child has a hard time making friends	
My child gets along with other children		My child fights with other children frequently	
My child has a lot of friends.		My child has very few or no friends.	
My child feels comfortable in social settings		My child feels uncomfortable in social settings	

Does your child have a best friend? YES NO If yes, first name: _____

How does your child get along with his/her parents? _____

How does your child get along with his/her siblings? _____

What activities does your child enjoy? _____

What are three strengths your child possesses? _____

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ACADEMIC HISTORY

Has your child ever repeated a grade? YES NO If yes, please describe: _____

Does your child have a learning disability? ____ If yes, indicate type: _____

What is your child's favorite and least favorite school subject(s)? _____

Please describe any issues or concerns you may have about your child's academics: _____

RELIGION

Does your family attend church? YES or NO If yes, what church do you attend? _____

Is your child involved in a youth group or church group? _____

MAJOR CONCERNS / STRESSORS

Please describe your concerns regarding your child/reason for attending counseling. _____

_____

_____

Of the concerns listed above, what is the most important concern today? _____

What do you hope for your child to gain from therapy?_____

_____

_____

Is there anything the counselor should know before the first session? _____

_____

PREVIOUS COUNSELING

Has your child had any therapy or counseling before? _____ What was the outcome? _____

If yes, list counselor and approximate dates: _____

In case of emergency please list the name and telephone number of two people in the area that could be called.

Name _____ Name _____

Telephone Number _____ Telephone Number _____

Relationship _____ _____ Relationship _____

If you were referred, please indicate by whom: _____

May I acknowledge your referral? Y N

All of the above information is true and correct to the best of my knowledge.

_____

Signature of client or guardian (if minor)

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CONSENT TO SERVICES

I. COUNSELING INFORMATION

This section explains certain policies and procedures and additional information regarding Tree of Life Counseling Center ("TOLCC"). At your first session, we will discuss your goals for counseling, confidentiality and frequency of appointments. The counselor's role is to provide you with a safe, confidential place where you can talk about your feelings, hurts, experiences and thoughts. Your role as a client is to be open, work towards goals that you set and be consistent with attending your appointments. Ultimately, the goals and decisions you make to encourage change are up to you; your counselor cannot change you. Most people experience some degree of relief after beginning counseling; although, some people feel worse before they start feeling better. This is a normal experience. However, if at any time you feel that you are not benefitting from treatment, please let your counselor know. You may end counseling at any time with no further obligations, although it is advised to have a final session for closure. If you feel that you are not comfortable with your counselor (or it is not a good fit), please let us know so that we can refer you to a counselor that you may be more comfortable. You have the right to ask questions about any techniques or procedures using during counseling.

Sessions are approximately 45-53 minutes long. The length of treatment varies for each client. Some people find relief quickly, and others may need a lengthier amount of time to work through more complex issues. There is no right or wrong amount of time for healing to take place. Sessions initially start out on a weekly or biweekly occurrence and then may progress to monthly appointments or termination of counseling.

II. THERAPEUTIC RELATIONSHIP

Although sessions may be very intimate psychologically, the relationship you have with your counselor is a professional one rather than a social one. Contact will be limited to counseling sessions except when you need to schedule or change an appointment. On occasion, it is necessary for a client to contact the counselor by telephone outside of the regular therapy session to discuss an issue. You will be asked to leave a message and your counselor will return your call within 24 hours. Any phone calls over 15 minutes will be prorated at your regular rate. **In the event of an emergency, please call 911.**

According to ethical guidelines, we ask that you do not invite your counselor to social gatherings, offer gifts, ask your counselor to write you references, or attempt to relate to your counselor in any way other than the professional context of the counseling sessions. Our services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results for you.

You have the right to decide not to receive psychotherapy from us; we will be happy to provide you with the names of other qualified therapists. If you have any concerns or complaints about us, please discuss such matters with Cristin J. Lewis, MA, LPC. You have the right to address any complaints against Licensed Professional Counselors to the Texas State Board of Examiners of Professional Counselors, 1100 West 49th Street, Austin, Texas 78756, 1-800-942-5540. You have the right to address any complaints against Licensed Marriage and Family Therapists to the Texas Behavioral Health Executive Council, 333 Guadalupe St., Ste 3-900, Austin, TX 78701, 512-305-7700.

III. CONFIDENTIALITY

We are committed to providing privacy and confidentiality to each of our clients. As outlined in the "Notice of Privacy Practices" form, there are certain situations in which we are required by ethical or legal standards to reveal information obtained during therapy. These include the following:

- Evidence of being a harm to self or others
- Evidence of abuse of a minor, elderly or handicapped individual
- Court subpoena
- You are a client being treated by a Licensed Professional Counselor – Associate, Licensed Marriage and Family Therapist – Associate or Professional Counseling Student, in which case your sessions may possibly be discussed with the Associate's or Professional Student's Supervisor
- You have signed a consent for us to discuss your sessions with another clinician (or another person)

IV. CLIENT FINANCIAL CONSENT

All fees are outlined in greater detail in the Financial Consent and Disclosure Form.

- **FEES DUE AT THE TIME OF SERVICE:** All fees for counseling sessions are due at the beginning of each session unless other arrangements have been made in advance. Some counselors may run payment the morning of or 24 hours before your appointment. TOLCC accepts payment by exact cash, check or debit/credit card. Appointments for additional sessions cannot be made until your balance is paid or other payment arrangements have been made. The standard and customary fee for a session (a session is 45-53 minutes from start to finish) is $100.00 - $125. However, a limited number of reduced fee sessions are available for those in need of financial assistance. In addition, Associates offer a reduced rate of $60 - $75 per session, and Professional Counseling Students offer a reduced rate of $30 - $45 per session. If your session fee will be changing, you will be given a minimum of four weeks' notice prior to any change taking effect.
- **LATE CANCELLATIONS/NO-SHOWS:** Late Cancellations and No-Shows will be charged a fee in the full amount of your usual session rate. A "Late Cancellation" is defined as canceling your appointment within 24 hours of your appointment. A "No-Show" is defined as failing to attend an appointment and failing to cancel such appointment.

V. POLICIES REGARDING COURT, SUBPOENAS, AND ANY OTHER LEGAL MATTER

Counselors from TOLCC are not trained for any type of court work, not trained to advise on legal matters, and cannot evaluate cases for custody. Counselors from TOLCC are not trained to be expert witnesses in any matter. In the event that you are involved in any legal action that requires testimony or deposition of your counselor, a fee of $250.00 per hour will be charged portal to portal. This fee also includes time spent preparing for the testimony or deposition, legal fees incurred by counselors and making copies of any records involved. The client is responsible for this fee even if it is the opposing attorney requesting records, deposition, testimony, or other services. Should the court order require one of TOLCC's counselors to be present for court, deposition, or other judicial activity in less than 48 hours, an additional fee of $500.00 will be charged in addition to the regular hourly fee of $250.00, due to the counselor having to alter his/her client schedule on such short notice.

Counseling Associates and Professional Counseling Students are required to be accompanied by their supervisors at all court appearances. Clients of Associates and Professional Counseling Students will also be responsible for compensating the supervisor according to the supervisor's rates in addition the Associate's or Student's hourly court rate of $250 per hour.

Due to the nature of such requests, a deposit of $1000 will be required for prepayment. Any overage amounts will be refunded to the client within a reasonable amount of time. Requests for records in any legal matter pertaining to a minor will require either the signature of a custodial parent or a court order from the judge for a therapist to release any records.

I have read, understand and agree to the informed consent and policies stated above. I consent to participate in evaluation and/or treatment, and I have had my questions answered concerning this document to my satisfaction.

_____

Client signature Date

NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of the Notice of Privacy Practices (HIPPAA).

_____

Client signature Date