Wise County Christian Counseling
1650 S. FM 51 Suite 400
Decatur, Texas 76234
(940) 627-1618

Client Information Questionnaire

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully. Ask your therapist for clarification if you do not understand an item.

Full name ____ Date __________________

Address____

____

Phone numbers (List all that apply.): ____

Please indicate if a message can be left at any of these numbers:____

Age: _________ Sex: _____ Male _____Female Marital status: __________________________________

Occupation(s):____

Household family income (including child support, unemployment, disability, etc.): _____________

Religious preference: ________________________ Where do you attend? ________________________________

Check all of the following which reflect the parent figures currently in your home:
_____Single parent _____Both birth parents _____Birth parent & Step-parent _____Adoptive parents
_____Foster parents _____Grandparents _____ Other relatives
Other (Please explain):____

Briefly describe your reason(s) for seeking help:

____
____
____
____

What do you hope to accomplish through counseling?

____
____
____
____

How did you find out about us? ____

Have you ever consulted a professional counselor? _____YES _____NO
If yes, name of agency:____

How was counseling helpful then?

____
____
____

If applicable, briefly describe your marital history (divorce, # of marriages, etc):

____
____

Please list any medications that you are taking at present:

Have you ever considered suicide? _____YES _____NO If so, when?_______________________________________
Have you ever attempted suicide? _____YES _____NO If so, when?_______________________________________

Have you ever had struggles with an addiction of any type? If so, please describe:

Have you experienced any trauma that has impacted your life (ex. Parents' divorce, abuse, death of a close relative/friend)? If so, please describe:

Mark any of the following which are presently causing you difficulty (Put a * by the two most important items):

Abuse	Depression	Insomnia	Religion
Alcohol use	Divorce	Legal Matters	Sadness
Allergies	Drug use	Loneliness	Self-Concept
Anxiety	Education	Marriage	Self-control
Appetite	Energy	Memory	Separation
Assertiveness	Fears	Mood swings	Sexual problems
Asthma	Finances	Motivation	Shyness
Bed-wetting	Food	My past	Sleep
Bowels	Friends	My thoughts	Stress
Career Choices	Guilt	Nervousness	Suicidal thoughts
Children	Headaches	Nightmares	Temper
Concentration	Health problems	Parenting	Tiredness
Confusion	Inferiority	Parents	Ulcers
Dating	Infidelity	Premarital	Unhappiness
Decision-making	In-laws	Relaxation	Work

Please provide any additional information which you feel may be useful to your therapy.

List the members of your family and all others that are currently living in your home.

Name(s)	Age/Grade	Relationship	Occupation

Who has custody of minor children living in your home? ___________________________________

Is there any history of mental illness in the family, including yourself? (anxiety, depression, OCD, schizophrenia, bipolar, addictions, etc.)

____

____

____

____

Wise County Christian Counseling
1650 S FM 51 Ste 400
Decatur, TX 76234
940-627-1618

Informed Consent

Welcome to Wise County Christian Counseling. Thank you for choosing me for your counseling needs. Starting counseling is a major decision and you may have many questions. This document is designed to inform you about agency policies and procedures as well as your rights, so that you can consent to treatment. If you have other questions or concerns, do not hesitate to ask me about them.

My name is Beverly Ross and I am a Texas State Licensed Professional Counselor, and a member of The American Association of Christian Counselors and The American Counseling Association, I hold a Bachelor of Science degree from Stephen F. Austin University and a Master of Arts degree from Amberton University.

All information pertaining to your counseling experience, including the knowledge that you are being seen for counseling is strictly confidential. By law, information cannot be released without your consent, with the following exceptions:

- I have reason to believe that you are a danger to yourself or others
- I have reason to believe you intend to physically harm someone else
- I have reason to believe you are abusing or have abused a child or elderly person
- I am ordered by a court to disclose information

I assure you that my 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. Together we will work to achieve the best possible results for you. Other options for counseling include talking with other professionals, your clergy person, or choosing to let the situation remain the same. If you have any complaints, please discuss them with me. If you are not satisfied with the resolution of the problem, you have the right to call the Consumer Complaint Hotline at 1-800-942-5540.

I am dedicated to providing counseling services to my clients knowing certain financial limitations exist. Being a non-profit organization, I can set my fees at a lower rate. No family will be turned away because of lack of funds. This agency asks our clients to determine their fees by using a sliding scale. For every $10,000 your household brings home a year, please consider paying $10 a session, up to $120. (Example: if your family brings home $50,000 a year, please pay $50 a session.) Checks, cash or credit card will be accepted. Checks will be made payable to Wise County Christian Counseling. Because there is a waiting list for our services, we ask that you notify us at least 24 hours in advance if you are unable to come at your scheduled time. **If you do not notify us before the appropriate time, you will be charged $50 for the missed appointment.**

Your signature below indicates your understanding of and agreement to the terms and conditions stated on this form. If you have any questions, please feel free to ask for an explanation.

By signing this consent form, we give our permission for any or all of our family members including minors to enter into a counseling relationship with Beverly Ross at Wise County Christian Counseling. We do this of our own free will. We recognize there is no guarantee expressed or implied that our problems will be alleviated in coming to counseling, and that in some cases our situation/problems may initially worsen before they improve. We recognize that we can terminate counseling at any time that we choose.

Signature(s) of parents(s)/couple/individual:

Client: ________________________________ **Date:** _____________

Client: ________________________________ **Date:** _____________

Counselor: _____________________________ **Date:** _____________

Wise County Christian Counseling
1650 S. FM. 51 Suite 400
Decatur, Texas 76234
(940) 627-1618

Patient Consent for Use and/or Disclosure of HIPAA Defined Protected Health Information to Carry Out Treatment, Payment, and Healthcare Operations

I, ____, hereby state that by signing this consent, I acknowledge and agree as follows:

The Provider's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Provider to provide treatment to me, and also necessary for the Provider to obtain payment for that treatment and to carry out its health care operations. The Provider explained to me that the Privacy Notice will be available to me in the future at my request. The Provider has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Provider reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that may be used by the Provider:
___ Yes ___ No · A text message sent to the cell phone number provided.
___ Yes ___ No · Telephoning my home or cell and leaving a message on my answering machine or with the individual answering the phone.
___ Yes ___ No · Telephoning my office and leaving a message on my phone mail or with the individual answering the phone.
___ Yes ___ No · An email sent to the email address provided.

The Provider may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Provider to treat me and obtain payment for that treatment, and as necessary for the Provider to conduct its specific health care operations.

I understand that I have a right to request that the Provider restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Provider is not required to agree to any restrictions that I have requested. If the Provider agrees to a requested restriction, then the restriction is binding on the Provider.

I understand that this Consent is valid for seven years and that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Provider has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Provider has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Provider will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

______________________________	________________________________
Name of Individual (Printed)	**Signature of Individual**

_________________________________	________________________________
Signature of Legal Representative **(e.g., Attorney-In-Fact, Guardian, Parent if a minor)**	**Relationship to Patient**

Date Signed _____________ Witness: ____

Due to the length of our waiting list and our deep desire to help people, beginning January 1, 2017, there will be a $50 charge for all appointments not kept or broken without 24 hour notice.

Signature(s) of couple/individual

X_________________________________ _______________
Client signature Date

X_________________________________ _______________
Client signature Date

X_________________________________ _______________
Counselor signature Date

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours, your therapist and Wise County Christian Counseling) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, we may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if we believe it is necessary, we may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, we will respect that decision, as long as it is feasible and clinically appropriate.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, Wise CCC staff, our families and other clients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement.

Your signature at the bottom of this form indicates that you agree to each of the following:

- You will only keep your in-person appointment if you are symptom free.
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth.
- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time.
- If the lobby is closed, you will call the office or text your therapist when you arrive and they will let you know when it is time to come in to your appointment. When the lobby is open, you are welcome to continue this procedure if you wish.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with your therapist or Wise CCC staff.

- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.
- You will take steps between appointments to minimize your exposure to COVID.
- If you have a job that exposes you to other people who are infected, you will immediately let your therapist or Wise CCC staff know.
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let your therapist know.
- If a resident of your home tests positive for the infection, you will immediately let your therapist or Wise CCC staff know and we will then [begin] resume treatment via telehealth.

We may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that we are committed to keeping you, your therapist, Wise CCC staff and all of our families safe from the spread of this virus. If you show up for an appointment and your therapist or Wise CCC staff believe that you have a fever or other symptoms, or believe you have been exposed, we will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If your therapist or a Wise CCC staff member tests positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

___________________________ ___________________________
Client Date

Consent for Telehealth Consultation Wise County Christian Counseling
CONSENT FOR ZOOM CONSULTATION.
I understand that my health care provider wishes me to engage in a telehealth consultation. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider. I understand that a zoom consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the zoom consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
CONSENT TO ZOOM TELETHERAPY
Zoom is the technology service we will use to conduct teletherapy videoconferencing appointments. It is simple to use and the link for the meeting with password will be sent to you prior to your scheduled appointment.
By signing this document, I acknowledge: Teletherapy by zoom is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911. Though my provider and I may be in direct, virtual contact through the zoom neither zoom nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services. The zoom facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care. To maintain confidentiality, I will not share my zoom appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify: That I have read or had this form read and/or had this form explained to me. That I fully understand its contents including the risks and benefits of the procedure(s). That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

______________________________ ____________________
Client Date