

Family Focused Counseling
Vickie A. Beavers MS. LPC, LMFT, RPT
200 N. Rufe Snow Drive, Suite 121
Keller, Texas 76248
817-485-8321
Fax 817-485-8321

The therapist has a limited number of hours available each week. When a client cancels an Appointment without sufficient notice it not only prevents that client from their scheduled Appointment but may also disable other clients from utilizing that time.

FEES ARE DUE BEFORE SERVICES ARE RENDERED
(Please NO Credit Cards: Cash or Checks ONLY)

Client Responsibilities:

- To attend sessions. It is not the policy of this office to make reminder calls for upcoming appointments.
- To notify office of appointment cancellations within 24 hours of the scheduled appointment time. If you must cancel an appointment you will be subject to a fee of \$25.00 an hour if sufficient notice (24 hours) is not given.
- Should a nonattendance occur without sufficient notice (24 hours) prior to scheduled appointment time you will be subject to the \$25.00 nonattendance fee and all future scheduled appointments will be canceled. Should nonattendance occur numerous times without sufficient notice (24 hours) prior to the scheduled appointment time we will assume that you no longer desire our services and your treatment program will be terminated.
- Do not bring children to intake sessions or adult sessions unless prior arrangement was made with the therapist.
- PARENTS: Sessions are 50 minutes; it is preferable that you stay on premises. Should you leave, PLEASE RETURN ON TIME.

FEES ARE DUE BEFORE SERVICES ARE RENDERED

Client Signature

Date

Clients Medical History

Relevant medical conditions (past/present):

Is client currently under a doctor's care? Yes () No ()

Is client presently taking any medications? Yes () No ()

Medication	Dosage	Prescribing doctor	Why prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Hospitalizations

Date	Reason	Hospital
_____	Medical () Psychiatric () Chem. Dependency ()	_____
_____	Medical () Psychiatric () Chem. Dependency ()	_____
_____	Medical () Psychiatric () Chem. Dependency ()	_____

Facility/Counselor name	Previous Counseling Date	Reason for counseling
_____	_____	_____
_____	_____	_____

What brings you to counseling? _____

Who referred you here? _____

If filing on insurance please complete the following for the Insured:

Name: _____ **Date of Birth:** _____

Home Address: _____

Employer: _____

Employer Address: _____

Insured's SS #: ____ - ____ - ____ **Insurance Co:** _____

Ins. Co Address: _____

INS CO. PH #: _____

GROUP #: _____

POLICY #: _____

INSURED ID#: _____

CLIENT INFORMATION AND CONSENT

THERAPIST

The undersigned therapist is a licensed professional counselor and a licensed marriage and family therapist engaged in private practice providing mental health care services to clients directly and as an independent contractor/provider for various managed care entities.

MENTAL HEALTH SERVICES

While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation and feelings and move toward resolving your difficulties. The therapist, using his [or her] knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you feel it would be helpful or if this is recommended by your therapist.

APPOINTMENTS

Appointments are made by calling (817) 485-8321 Monday through Friday between the hours of 9:00 a.m. And 5:00 p.m. Phones are answered off site. **PLEASE CALL TO CANCEL OR RESCHEDULE AT LEAST 24 HOURS IN ADVANCE. MISSED SESSIONS, WITHOUT PRIOR NOTICE WILL BE SUBJECT TO A MINIMUM CHARGE OF \$25.00 AN HOUR.**

NUMBER OF VISITS

The number of sessions needed depends on many factors and will be discussed by the therapist.

LENGTH OF VISITS

Therapy sessions are 50 minutes in length but may take longer for psychological testing.

RELATIONSHIP

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you.

Gifts, bartering and trading services are not appropriate and should not be shared between you and the therapist.

GOALS, PURPOSES AND TECHNIQUES OF THERAPY

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the therapist and to have input into setting the goals of your therapy. As therapy progresses these may change. The initial goals, purposes and techniques of therapy agreed upon by you and the therapist are as follows:

CANCELLATIONS

CANCELLATIONS MUST BE RECEIVED AT LEAST 24 HOURS BEFORE YOUR SCHEDULED APPOINTMENT; OTHERWISE YOU WILL BE CHARGED THE CUSTOMARY FEE FOR THAT MISSED APPOINTMENT. YOU ARE RESPONSIBLE FOR CALLING TO CANCEL OR RESCHEDULE YOUR APPOINTMENT.

PAYMENT FOR SERVICES

The charge for your initial session is \$_____ and the charge for any subsequent sessions is \$_____. The undersigned therapist does not normally accept assignment of insurance benefits but may be required to do so in connection with certain managed care contracts. **THE UNDERSIGNED THERAPIST WILL LOOK TO YOU FOR FULL PAYMENT OF YOUR ACCOUNT, AND YOU WILL BE RESPONSIBLE FOR PAYMENT OF ALL CHARGES.** Different co-payments are required by various group coverage plans. Your co-payment is based on the mental health policy selected by your employer or purchased by you. In addition, the co-pay may be different for the first visit than for subsequent visits. You are responsible for and shall pay your co-pay portion of the undersigned therapist's charges for services at the time the services are provided unless otherwise arranged. It is recommended that you determine your co-payment before your first visit by calling your benefits office or insurance company.

Although it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records and the therapist's normal hourly rate for the time involved in preparing for and giving testimony. Such payments are to be made at the time or prior to the time the services are rendered by the therapist. Therapist may require a deposit for anticipated court appearances and preparation.

CONFIDENTIALITY

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with a licensing board or other state or federal regulatory authority. **FOR FURTHER INFORMATION REVIEW THE NOTICE OF PRIVACY PRACTICES FURNISHED TO YOU BY YOUR THERAPIST IN CONJUNCTION WITH THIS CLIENT INFORMATION AND CONSENT DOCUMENT.** If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN

In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact any person in position to prevent harm to myself or another person, in addition to medical and law enforcement personnel, and the following persons:

NAME

TELEPHONE NUMBER

This information is to be provided at my request for use by said persons only to prevent harm to myself or another person. This authorization shall expire upon the termination of my therapy with the undersigned therapist.

I acknowledge that I have the right to revoke this authorization in writing at any time to the extent the undersigned therapist has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be permitted by law as indicated in the copy of the notice of privacy practices of the undersigned therapist that I have received and reviewed.

I acknowledge that I have been advised by the undersigned therapist of the potential of the re-disclosure of my protected health information by the authorized recipients and that it will no longer be protected by the federal privacy rule.

I further acknowledge that the treatment provided to me by the undersigned therapist was conditioned on my providing this authorization.

CONTACT INFORMATION

I consent for the undersigned therapist to communicate with me by mail, email and by phone at the following addresses and phone numbers, and I will IMMEDIATELY advise the therapist in the event of any change:

ADDRESS

TELEPHONE NUMBER

RISKS OF THERAPY

Risks include feelings of sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of exercising the divorce option.

AFTER-HOURS EMERGENCIES

When your therapist's office is closed please call JPS Hospital at 817-927-1222 or 911. Emergencies are urgent issues requiring immediate action.

THERAPIST'S INCAPACITY OR DEATH

Therapy is the Greek word for change. You may learn things about yourself that you don't like. Often, growth cannot occur until you experience and confront issues that induce you_

I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice. I will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

CONSENT TO TREATMENT

I voluntarily agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. **MISSED SESSIONS, WITHOUT PRIOR NOTICE OF NON-ATTENDANCE, WILL BE SUBJECT TO A MINIMUM CHARGE OF \$25.00 AN HOUR.**

Client/Parent _____
Date

SOCIAL SECURITY NUMBER AND ADDRESS: _____
SSN Address

City State Zip

as witnessed by:

Vickie Beavers, LPC _____
Date

I acknowledge that I received a copy of this signed intake and consent form from my therapist on this ____ day of _____, 20__.

Client

DATABASE INFORMATION SHEET

Please Print Clearly

Date: _____

Client Last Name _____

First Name _____

Home Phone _____ May we contact you at this number Yes No

Work Phone _____ May we contact you at this number Yes No

Cell Phone _____ May we contact you at this number Yes No

Address: _____

E Mail Address

May we contact you at this email Yes No

Parent or guardian name if client is a
minor _____

DIRECTIONS to:

**Family Focused Counseling
Vickie A. Beavers MS. LPC, LMFT
200 N. Rufe Snow Drive, Suite 121
Keller, Texas 76248
817-485-8321
Fax 817-485-8321**

I-35W (North of north loop I-820)

- Exit 64 GOLDEN TRIANGLE BLVD.
- Turn East on Golden Triangle Blvd. (FM 1709)
- At Hwy 377, it becomes known as “Keller Parkway”
- Travel about 1.5 miles east of Hwy 377.
- Turn LEFT (north) at RUFÉ SNOW DR. (There is a McDonalds there at the northwest corner of the intersection)
- Turn left at the first driveway on your left.
- Building is on your left (south side of parking area).

HWY 114 “Northwest Parkway” (North West of DFW Airport)

- Exit E. SOUTHLAKE Blvd.
- Turn West
- Travel for about 7.5 miles till you get to RUFÉ SNOW DR.
- Turn RIGHT (north) on RUFÉ SNOW DR.
- Turn left at the first driveway on your left.
- Building is on your left (south side of parking area).

I-820 (North Loop)

- Exit 20B RUFÉ SNOW RD.
- Turn NORTH
- Travel about 6.6 miles north.
- After crossing KELLER PARKWAY (FM 1709)
- Turn left at the first driveway on your left. (Beyond McDonalds on your left)
- Building is on your left (south side of parking area).