

Next Step Counseling and Education Center
4702 N. Laurent St. Suite D. 415 E. Davis St. Suite F & G
Victoria, TX, 77904 Luling, Tx, 78648
Phone: (361)572-0202
Fax: (361) 572-0300

Statement of Understanding and Consent for Treatment

BENEFITS AND RISKS OF THERAPY:

Research has shown that therapy can help a wide variety of problems for children, adolescents, and adults. However, because therapy is a cooperative effort between client and therapist, participation in therapy does not guarantee problem resolution or that the client necessarily will feel better. As with any treatment, whether psychological or medical, therapy should be entered into with appropriate consideration of the potential benefits and risks. If you have any questions about what to expect from therapy, please ask your therapist.

CONFIDENTIALITY:

Records and information collected about clients will be held and released in accordance with state and federal laws governing confidentiality of client records and information.

Disclosure of information regarding services provided to the client is generally released to another party only with the client's written permission. Exceptions to this rule include the following cases:

- 1) when there is imminent danger to the client or another person,
- 2) when child abuse or neglect is suspected,
- 3) when disclosure must be made to medical personal in a medical emergency, and
- 4) when the therapist is compelled by law to disclose client records or information.
- 5) when services have been ordered by a court, regular reports are generated and submitted to the ordering court and/or referring attorneys

CLIENTS WITH DISABILITIES:

It is the policy of **Next Step Counseling** to accommodate clients with disabilities, pursuant to federal and state law. Any client with a disability who needs accommodations should inform the therapist prior to receiving services.

NONDISCRIMINATION POLICY:

In accordance with Title VI of the Civil Rights Act of 1964 **Next Step Counseling** does not discriminate against participants or clients on the basis of race, color, or national origin. Services are offered to all eligible persons.

Next Step Counseling and Education Center

CONSENT FOR TREATMENT/RESPONSIBILITIES OF CLIENTS:

I do hereby authorize and give my consent to **Next Step Counseling** to provide treatment in accordance with the customary standards of practice specified by the state and federal laws, regulatory agencies, and professional discipline governing **Next Step Counseling**.

Next Step Counseling does not overbook appointments. Each appointment is a reservation of resources specifically for you. Applicable charges are made for appointments not canceled within 24 hours prior to the appointment.

I have read, understand and agree to the conditions of treatment described in this document.

Client Printed Name

Client / Parent or Guardian Signature

Date

Next Step Counseling and Education Center

NOTICE

The purpose of counseling is to help people use their existing problem-solving skills more efficiently or to develop new or better coping skills. Our job is to provide an opportunity for the client to express their feelings, problems, and concerns and to aid them in reaching decisions and actions that are based on informed choices. Our counselors utilize the following techniques: Cognitive Behavioral, Solution-Focused, Family Systems, play therapy, Client Centered, and Integrated. Individual, family, marriage, and group therapies are offered.

There may be a time during our communications when issues arise that have some relationship to your rights or duties under the law. Please remember that our counselors are not attorneys. **We will not provide any legal services to you, directly or indirectly.** If at any time you have any questions concerning your legal rights or duties, please ask your lawyer about them.

Our purpose in providing services to you is as a professional counselor licensed with the state of Texas. The goal is to assist in the resolution of whatever issues concern you or your children. Sometimes we are appointed by the court to be involved; sometimes we are asked by an attorney to assist in a family situation, and sometimes one or more family members request our professional guidance in dealing with family issues.

No matter how we are invited to participate in a situation, and despite the extent to which we may become involved with you and your family, we do not supplant the role of your licensed attorney in dealing with questions concerning the law, just as he/she would not extend themselves into our area of expertise, which involves professional counseling.

In the event that a therapist passes away or is no longer in practice, your records will be in the custody and control of one of the other therapists at Next Step Counseling and Education Center.

Recordings of phone calls and/or face-to-face sessions are prohibited without the expressed written consent of the individual counselor. Any part or in whole records that are requested must be done in writing.

If you have a complaint, please address it with your counselor first in order to receive a prompt resolution. In the event a resolution is not reached, you may contact:

Texas State Board of Examiners of Professional Counselors

P.O. Box 149347

Austin, Texas

78714-9347

(512)834-6658

Signature: _____

Date: _____

Next Step Counseling and Education Center

Fee Schedule

Therapy Sessions	Vary Based on Income
Diagnostic Summary Reports	\$250
Copies of Records	\$20 + .50¢ per page
Court Testimony (Non-refundable)	\$200 per hour; minimum of 3 hours
Phone Sessions/Conference	Vary Based on Income
Virtual Sessions	Vary Based on Income

Next Step Counseling and Education Center utilizes a sliding scale fee based on the **Combined Gross Household** annual income. The sliding scale is listed below:

≤\$40,000- \$45/Session	\$60,001-\$65,000- \$80/Session
\$40,001-\$45,000- \$50/Session	\$65,001-\$70,000- \$85/Session
\$45,001-\$50,000- \$60/Session	\$70,001-\$75,000- \$90/Session
\$50,001-\$55,000- \$70/Session	\$75,001-\$80,000- \$100/Session
\$55,001-\$60,000- \$75/Session	≥\$80,001- \$125/Session

Note: While emails are always encouraged, please be aware that excessive emails requiring a response may be billed at the rate as phone calls.

All fees are due at the time of services rendered unless other arrangements have been made.

Note: If your litigation specifies that another party pays for your legal fees, you are still responsible for the fee at time of service.

If you need to cancel your appointment, please call 24 hours prior to your scheduled appointment, otherwise there may be a 50% cancellation fee charged toward your account.

If the balance of your account is not reconciled within 30 days of the last activity, we reserve the right to utilize the services of a collection agency.

I have read and agree to the information outlined above.

Signature of Client(s)/Parent(s)/or Legal Guardian(s): _____ Date: _____

Next Step Counseling and Education Center

Client Information Sheet

CLIENT INFORMATION

Name: _____ DOB: _____ M ___ F ___
Address: _____ City: _____ State: _____ Zip: _____
SSN: ____-____-____ TDL# _____
Cell Phone: _____ Work Phone: _____ Home Phone: _____
Email: _____
In case of emergency call: _____ Relationship to client: _____
Emergency Contact Phone: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ DOB: _____ M ___ F ___
Address: _____ City: _____ State: _____ Zip: _____
Marital Status: Single Married Divorced Other SSN: ____-____-____
Relationship to Client: Mother Father Other: _____
Cell Phone: _____ Home Phone: _____ Other Phone: _____

PRIMARY INSURANCE INFORMATION

Insured's Name: _____ DOB: _____ M ___ F ___
Address: _____ City: _____ State: _____ Zip: _____
Marital Status: Single Married Divorced Other SSN: ____-____-____
Private Insurance Company: BCBS United Amerigroup
Medicaid: Traditional Medicaid Driscoll/CHIP Star Plan/Star Health Superior
ID#: _____ Group #: _____ Employer: _____
Telephone Number for Provider: _____
Is there a secondary insurance provider? Yes No Secondary Provider: _____ ID#: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ASSIGN ALL BENEFITS TO THE PROVIDER. I UNDERTSTAND THAT MISSED APPOINTMENTS WILL BE CHARGED A CANCELLATION FEE UNLESS A 24-HOUR NOTICE IS GIVEN. PLEASE NOTE HMO PLANS HAVE A DEDUCTIBLE THAT MUST FIRST BE MET.

Signature: _____ Date: _____

Next Step Counseling and Education Center

Client Information

Name: _____ DOB: _____ M ___ F ___

Address: _____ City: _____ State: _____ Zip: _____

SSN: ____ - ____ - ____ Race/Ethnicity: _____ Religious Affiliation: _____

Highest Grade of School Completed: _____ Email: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Special Calling Instructions: _____

Is it OK to call the number listed above? Yes No Which? Cell Work Home

Is it OK to leave a message at the number selected above confirming your appointment? Yes No

Marital/Relationship Status (Check One):

Married Living with Partner Single Divorced/Separated Widowed Other

Spouses Name: _____ DOB: _____ Age: _____

Employment Status (Check all that apply):

Employed Retired Disabled Student Homemaker Unemployed

If/When employed what type of work do you do? _____

Current Employer: _____ Years on Current Job: _____ Business Phone: _____

Is it OK to contact you at work?: Yes No Is it OK to leave a message? Yes No

Special Calling Instructions: _____

Emergency Contact:

Name: _____ Relationship to Client: _____

Phone number: Daytime: _____ Evening: _____

Next Step Counseling and Education Center

Reason for Seeking Treatment

Please briefly describe the nature of the problem: _____

What has happened to cause you to seek help *now*?: _____

What do you hope to be able to do or achieve as a result of treatment?: _____

History of the Problem

When did you first start experiencing the problem(s) that brought you to the office today?:

How often does the problem occur?: _____

How long does it last?: _____

Do you have any thoughts of harming yourself? Yes No

Have you ever attempted to harm anyone else? Yes No

If YES, Please explain: _____

**Anyone with suicidal urges should seek immediate help from a mental health professional.

Have you ever had previous therapy/counseling of any kind? Yes No

If YES, when and for how long?: _____

What concerns were addressed in treatment: _____

Was this experience helpful? Yes No

Please Explain: _____

Have you ever been hospitalized for emotional/behavioral concerns: Yes No

If YES, when/where were they?: _____

Next Step Counseling and Education Center

Are you currently being treated by another mental health professional? Yes No

If YES, from whom?: _____ How long? _____

Have you ever been prescribed medications to control emotional/behavioral problems? Yes No

If YES, please list medications, when prescribed, and by whom: _____

Medical Information

Name: _____ Date: _____

Which of the following illnesses or complaints have you (the client) experienced?

Diabetes Head Injury Ulcer Irregular menses

High Blood Pressure Thyroid problems Glaucoma Difficulty Sleeping

Epilepsy Seizures Dizzy Spells Loss of Appetite

Liver problems Hepatitis PMS Herpes

Kidney problems Asthma Back Pain Sexually Transmitted

Headaches/Migraines Respiratory problems Frequent constipation disease(s)

Heart attack Stroke Loss of consciousness Other _____

What prescription medications are you currently taking and why?

1. _____

3. _____

2. _____

4. _____

What over the counter medications do you regularly take? _____

Name and Phone number of your **Primary care Physician**: _____
