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.

CONSENT FOR TREATMENT/RESPONSIBILIES 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

Counseling Sessions	Vary Based on Income
Diagnostic Summary Reports	$250
Copies of Records	$20 Base Rate + 0.50¢ 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.

Signature: _____ Date: _____

Next Step Counseling and Education Center

Client Intake Assessment Form

Client/Minor 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

Mother's Information

__ Please check here if this is a foster/adoption case.

Mother's Name:_____DOB:_____ M____ F____

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

Race/Ethnicity:_____ Religious Affiliation:_____

Highest Grade of School Completed:_____ Email: _____

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

Special Calling Instructions:_____

Mother's Marital/Relationship Status (Check One):

___Married ___Living with Partner ___Single ___Divorced/Separated ___Widowed ___Other

Spouses Name: _____ DOB: _____ Age: _____

Mother's Employment Status (Check all that apply):

___Employed ___Retired ___Disabled ___Student ___Homemaker ___Unemployed

If/When employed what type of work do the mother do? _____

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

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

Father's Information

__ Please check here if this is a foster/adoption case.

Father's Name:_____DOB:_____ M____ F____

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

Race/Ethnicity:_____ Religious Affiliation:_____

Highest Grade of School Completed:_____ Email: _____

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

Special Calling Instructions:_____

Father's Marital/Relationship Status (Check One):

___Married ___Living with Partner ___Single ___Divorced/Separated ___Widowed ___Other

Spouses Name: _____ DOB: _____ Age: _____

Father's Employment Status (Check all that apply):

___Employed ___Retired ___Disabled ___Student ___Homemaker ___Unemployed

If/When employed what type of work do the father do? _____

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

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

Guardian (if other than Parent) Information

__ Please check here if this is a foster/adoption case.

Guardian Name:_____DOB:_____ M____ F____

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

Race/Ethnicity:_____ Religious Affiliation:_____

Highest Grade of School Completed:_____ Email: _____

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

Special Calling Instructions:_____

Guardian's Marital/Relationship Status (Check One):

___Married ___Living with Partner ___Single ___Divorced/Separated ___Widowed ___Other

Spouses Name: _____ DOB: _____ Age: _____

Guardian's Employment Status (Check all that apply):

___Employed ___Retired ___Disabled ___Student ___Homemaker ___Unemployed

If/When employed what type of work do the guardian do? _____

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

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

Reason for Seeking Treatment

Please briefly describe the nature of the problem: _____

_____

_____

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

_____

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

_____

History of the Problem

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

_____

How often does the problem occur?: _____

How long does it last?: _____

Does your child have any thoughts of harming themself? Yes No

Has your child 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.

Has your child 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 your child ever been hospitalized for emotional/behavioral concerns: Yes No

If YES, when/where were they?: _____

Is your child currently being treated by another mental health professional? Yes No

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

Has your child ever been prescribed medications to control emotional/behavioral problems? Yes No

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

_____

To your knowledge, has your child experimented with drugs/alcohol? Yes No

Are you concerned your child might have or be developing a problem with drugs/alcohol? Yes No

If YES, please explain: _____

Family

Has this child ever experienced any parental separations, divorce or death?: Yes No

If YES, when? _____ How old was the child at the time? _____

Please describe the circumstance: _____

_____

If parents are separated, divorced, or deceased, who has custody of the child? _____

How often does the other parent see the child (please select one)

___ Weekly or more often

____ Once or twice a month

____ Few times a year

____ Never

In the Home

Please list the ages and sex for everyone else living in the home

Age	Sex	Relationship to Child

Has anyone in the home had treatment for emotional problems: Yes No

If YES, please explain who/when: _____

Has anyone in the family ever attempted or completed suicide? Yes No

If YES, please explain who/when: _____

Client Medical Information

Name: _____ Date: _____

Which of the following illnesses or complaints has 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 is the client currently taking and why?

1. _____
_____
_____

2. _____
_____
_____

3. _____
_____
_____

4. _____
_____
_____

What over the counter medications does the client regularly take? _____

_____

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

_____

When was the last time they saw their doctor? _____

For what reason? _____

When was the last time they had a physical? _____

Family Health

Have any family members had any of the following (please check if yes and specify family member's relationship to the child).

__ Tourette's Syndrome: _____

__ Behavior Disorder: _____

__ Depression: _____

__ Mental Illness: _____

__ Mental Retardation: _____

__ Nervousness: _____

__ ADD/ADHD: _____

__ Anxiety: _____

__ Alcohol/Drug Abuse: _____

__ Bipolar Disorder: _____

__ Other: _____

Child's Education

Please describe difficulties or problems your child is experiencing at school/in the classroom, if any:
_____

_____

Child's Current Grade Level: (circle one)

Elementary (K 1 2 3 4 5) Middle School/Jr. High (6 7 8) High School (9 10 11 12)

Other: _____

Child's Development

__ Please check if this is a foster/adoption case

Was this a planned pregnancy?: Yes No

Was the mother under a doctor's care?: Yes No

Number of previous pregnancies/miscarriages: _____

Descibe any complications that occurred during the pregnancy: _____

_____

What drugs or medications were used during the pregnancy: _____

At this birth what was the mother's age? ____ Father's age? _____

Length of pregnancy? _____ Weeks Birth weight? __ lbs __ oz Length of labor?: _____

Child's condition at birth? _____

Mother's condition at birth? _____

When was child weaned? _____

At what age was the child toilet trained? Days _____ Nights _____

Language difficulties? Yes No If YES, please describe: _____

Delays with walking? Yes No If YES, please describe: _____

Were there any other problems experienced during the child's first years? If YES, please explain:
_____

Current

Describe sleep patterns or problems: _____

Does the child have problems getting along with others? If YES, please describe: _____

_____

Child Interests and Activities

Is this child involved in any extracurricular activities such as school sports or music programs, clubs, religious organizations? Yes No If YES, please describe: _____

Please describe child's strengths and positive characteristics: _____

_____

Please list any other information you feel is important and was not listed previously:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Next Step Counseling and Education Center
4702 N. Laurent St.
Phone: (361)572-0202
Fax: (361) 572-0300

Patient Consent for Use and Disclosure of Protected Health Information (HIPPA Acknowledgement)

I hereby give my consent for Next Step Counseling and Education Center to use and disclose **protected health information (PHI)** about me to carry out **treatment, payment and health care operations (TPO)**. (The Notice of Privacy Practices provided by Next Step Counseling and Education Center describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Next Step Counseling and Education Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Next Step Counseling and Education Center.

With this consent, Next Step Counseling and Education Center may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

With this consent, Next Step Counseling and Education Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, Next Step Counseling and Education Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Next Step Counseling and Education Center restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Next Step Counseling and Education Center to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Next Step Counseling and Education Center may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian Date

_____ _____
Print Patient’s Name Date

_____
Print Name of Patient or Legal Guardian (if applicable) Date

_____
Witness Date