NEW CLIENT FORM - MINOR
His Story Coaching & Counseling
Client Demographic Information

Please fill your current demographic information. By signing this document, you are consenting to have your demographic information stored in our HIPAA compliant online portal and consenting to receive appointment reminders by the method of your choice.

Name:_____ Birth Date: _____

Address:_____

_____

Email:_____

Phone Number:_____

May we contact you by phone? Yes No

May we leave a message? Yes No

May we contact you by email? Yes No

May we contact you by mail? Yes No

May we remind you by email? Yes No reminders

Guardian Signature:

_____

NEW CLIENT FORM - MINOR
His Story Coaching and Counseling
Updated 11.1.2021

Welcome! It is our desire to ensure that your participation in counseling is a productive and satisfying one. In order to facilitate a therapeutic relationship, we have set forth certain information, which will enable you to make an informed consent to counseling.

His Story Coaching and Counseling is a non-profit entity comprised of a team of professional counselors and coaches who provide quality service and care. Each counselor has their own personality and implements their own style of proven counseling techniques. We have done our best to place you with a counselor that we feel will work well with you and your schedule. All of our counselors use an approach to counseling which takes into account the spiritual, psychological, social, and biological dimensions of the client and strive to establish and maintain a relationship with you, the client, characterized by equality and cooperation that allows you to explore needs, perspectives, and goals. Our team will seek to offer appropriate suggestions and vehicles to encourage the achievement of your child's goals.

INFORMATION

Counseling Services and Risks of Counseling

___ (Initial) The number of sessions needed depends on many factors and is different for every client. The client understands it is up to the client and the counselor to determine the number and frequency of sessions necessary and that this may change throughout the course of counseling.

It will be important for the client to explore their own feelings and thoughts and to try new approaches in order for change to occur. Often, growth cannot occur until you experience and confront issues that may induce the client to feel sadness, sorrow, anxiety, or pain. The success of the client's work together with the counselor depends on the quality of the efforts on both parts, and the realization that the client is responsible for lifestyle choices/ changes that may result from therapy. The client and their guardians have the right to refuse or negotiate modification of any technique that is concerning. Possible positive or negative effects of entering or not entering counseling and/or using or not using certain techniques may be discussed at any time during the relationship at the initiation of either the client or the counselor. The client may bring other family members to a counseling session if it would be helpful or if it's recommended and you agree. However, this must be discussed and agreed upon before the individual joins the session.

Relationship

The client's relationship with the counselor is a professional and therapeutic relationship. In order to preserve this relationship, it is important that your counselor limit other types of relationships with you and your child. Personal and/or business relationships may undermine the effectiveness of the counseling relationship and are unethical. Out of respect for your privacy, the child's counselor will not initiate

conversation with you in a social setting and will be brief if you initiate contact. Also, the counselor will not enter into any non-counseling business or personal relationships with the client or the client's family that could be harmful to the counseling relationship.

Goals, Purposes, and Techniques of Therapy

Our counselors use a variety of techniques and theories in therapy. It is important for you to discuss any questions you may have regarding the treatment recommended by the counselor and to have input into setting the goals of your therapy. We also believe that prayer, Bible study, and the power of the Holy Spirit within an individual are among the resources that can be applied, if the client should choose. If the client or guardian wishes not to have these methods as a part of counseling, please inform the counselor. The client, guardians, and the counselor will discuss goals during the initial session and throughout therapy. As therapy progresses, these goals may change.

Appointments & Cancellations

___ (Initial) Appointments are made by calling **817-906-1111** Monday through Thursday between the hours of 9:00 am and 6:00 pm. Messages left outside these hours will be returned the next business day.

___ (Initial) Therapy sessions are approximately 45 to 50 minutes in length but may be longer if agreed upon by counselor and client. The client may end the relationship at any point. We request that the termination include one week's notice in writing.

___ (Initial) Cancellations should be received as soon as you are aware that you will miss your scheduled appointment. Due to high demand for counseling services, we require 24 hours' notice for cancellation of an appointment, which makes an appointment possible for someone else. A cancellation fee of $50 will be charged for missed appointments or for appointments cancelled with less than 24 hours' notice. Payment for missed/late appointments will be due at the next scheduled appointment. Cancellations may be made by phone to 817-906-1111 during business hours or by emailing your counselor at their email address which is their first name followed by "@his-story.org" and the office staff at info@his-story.org. If the client cancels or no shows three times, the counselor will not hold the time slot and reserves the right to terminate services or refer the client to another counselor.

Phone Consultations

___ (Initial) Phone consultations with clients or parents of minor clients will be free of charge for emergencies or other calls lasting less than 10 minutes in length if the counselor agrees the call is necessary and appropriate. If a phone consultation lasts longer than 10 minutes, it is office policy that we schedule a session in order to discuss the issue. If you wish to continue the conversation more than 10 minutes, you will be charged $20 for up to 20 minutes and the full fee of a session for phone consults lasting longer than 20 minutes. Fee is to be paid to our office at the time of your next session.

E-mail Communication

___ (Initial) The client or guardian may contact the counselor by e-mail between sessions. It's important to understand that the counselor may respond, but will be brief. Also, understand that there are risks associated with communicating by email. If at any point throughout the counseling process the counselor believes that the client or guardian are using e-mail to replace face-to-face counseling or are using e-mail too frequently between sessions, the counselor has the right to set limits on e-mail communication and/or deny the privilege to have further e-mail communication with the counselor.

Payment for Services

___ (Initial) The fee for a counseling session will depend on who you see and any other arrangements made. Our fee schedule is as follows:

- All Clients for PHD staff $120 per session
- LPC or LMFT $105 per session
- LPC-Associate $95 per session
- Graduate Level Practicum students $65 per session

All fees are to be paid at the time of service by check, cash, credit card or Venmo. If requested, the guardian paying for services will be provided with a receipt.

By signing this document, the guardian is consenting to allowing our office manager, or another appointed staff member, to have knowledge of your identity when paying. They understand the necessity of maintaining strict confidentiality of these records and agree to maintain the records under strict confidentiality guidelines.

No insurance will be filed by the counselor. If the guardian wishes to file out of network benefits with their insurance, the guardian will be responsible for filing all documents. In this case, the guardian will be responsible for paying in full at the time the services are rendered. The office will then supply an appropriate receipt at the time of the client's next session. However, no guarantees are made that the client will be reimbursed by their insurance company.

Legal Actions & Fees

___ (Initial) I, the guardian, agree to hold His Story, the counselor and the counselor's heirs harmless for any alleged or perceived controversies, damages or claims arising out of the rendering of services agreed upon herein. However, in the event that I disregard the terms of this agreement and initiate legal action against my counselor for whatever reason, and the counselor must testify in defense of or otherwise defend self, confidentiality cannot be assumed. It is understood that the counselor will offer whatever information is deemed appropriate and necessary to defend themself against any legal action initiated by the guardian or as a result of their actions.

___ (Initial) I understand that although it is His Story's goal to protect the confidentiality of my child's records, there may be a time when disclosure of records or testimony will

be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event that disclosure of my records or my counselor's testimony are requested by me or required by law, **I, the guardian, will be responsible for and shall pay the costs involved in preparing for and giving testimony**. Fees for court appearances or consults with lawyers will be $200 per hour to cover the cost of my counselor's time away from clients and office responsibilities. If the consultation or court appearance takes place off site from the His Story office, the hour will start when my counselor leaves the office and will end upon my counselors return to the office. Such payments are to be made at the time the services are rendered. His Story may require a deposit for anticipated court appearances and preparation.

In accordance with state standards, His Story will follow the following fee schedule for copies of mental health records. These fees are to be paid by you before the records are released unless there is an emergency situation:

- A basic retrieval and processing fee of $30, which includes the cost of the first 10 pages copied.
- Pages 11 to 400 will be .25 cents per page
- The actual cost of mailing, shipping, or delivering the copies
- No fee will be charged for billing records or the first copy of mental health records that are requested for disability purposes.

Charges for copies for other purposes, such as copies of decrees or other documents that are required to be in the file that I, the guardian, fail to provide a copy of or copies of other documents I wish to be stored in the file, will be charged .25 cents per page, payable at the time the copy is made.

Confidentiality

___ (Initial) I understand that discussions between the counselor and the client are confidential. No information will be released without the guardian's written consent unless mandated or allowed by law. The counselor is legally required to break confidentiality in the event of child abuse or abuse of the disabled or elderly. Confidentiality will be broken if in the counselor's judgment the client becomes a danger to themselves or others. As necessary, my child's treatment issues and needs will be shared with my counselor's clinical supervisor and may be shared with the directors of the counseling center or other counseling professionals in a consultation manner for the purpose of supervision and enhancing your progress. For further information, I can review the Notice of Privacy Practices available online and posted in the His Story offices. Questions regarding my confidentiality should be brought to the attention of the counselor when we can both discuss this matter further.

By signing this information and consent form, I, the guardian, am giving my consent to the undersigned counselor to share confidential information with all persons mandated by law as well as supervisors and directors, and I am also releasing and holding harmless the undersigned counselor from any departure from your right of confidentiality that may result.

In the event that the undersigned counselor reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for my counselor to inform the following person in order to help ensure my safety:
(please draw a line through and initial if you wish to not name an emergency contact)

Name _____ Relationship: _____

Phone _____ Guardian's Initials: _____

This information is to be provided at the guardian's request for use by said persons, only to prevent harm to my child or another person. This authorization shall expire upon the termination of my therapy with the undersigned counselor.

___ (Initial) I, the guardian, acknowledge that I have the right to revoke this authorization in writing at any time to the extent the undersigned counselor 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 child's protected health information could possibly still be permitted by law as indicated in the copy of that Notice of Privacy Practices of the undersigned counselor that I have received and reviewed. I acknowledge that I have been advised by the undersigned counselor 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 my child by the undersigned counselor was conditioned on my providing authorization.

Video Security Camera Use on Property:

___ (Initial) I, the guardian, understand that for the safety and security of all clients and staff at His Story, video security cameras are in use in all rooms and offices. Footage is not stored as a part of my file and is located on a secure server, only accessible by the Executive Director and Privacy Officer for His Story, Matthew LaGrange, Ph.D and the His Story staff. There is no audio recording on cameras located inside counseling offices.

Right to View Files

___ (Initial) I have the right to copies of my child's entire file but acknowledge some information may not be in my best interest to review. In the event my counselor, in the exercise of their professional judgment, determines that information in my file may be injurious to me, I waive my right to obtain such potentially injurious information and release my counselor from any and all claims, damages, and causes of action that I suffer or could assert for his refusal to provide me with the information requested. The counselor's discretion shall control.

After-Hours Emergencies

___ (Initial) I acknowledge that if I need to contact the counselor during non-business hours, I can leave a message on the office voicemail (817-906-1111) or send an e-mail with a brief message. The counselor will respond on the next business day unless other

arrangements have been made. If I have an emergency which requires immediate action, I will call 911, call the county Crisis/Suicide number at 1-866-672-5100 or go to my local emergency room.

Counselor Incapacity or Death

___ (Initial) I acknowledge that, in the event that the undersigned counselor becomes incapacitated or dies, it will become necessary for another counselor to have access to my files and records. All files generated with regard to the client's care will be maintained in the counseling offices at His Story Coaching and Counseling under the care of the current Directors and/or Office Manager of His Story Coaching & Counseling. By signing this information and consent form, I give my consent to allow the current directors and/or office manager to have access to the clients file and records and provide me with copies upon request or to deliver them to a mental health professional of my choice.

Consent to Treatment

___ (Initial) I voluntarily agree for my child to receive assessment, care, treatment, or services, and authorize the undersigned counselor to provide such care, treatment, or services as are considered necessary and advisable.

___ (Initial) I understand and agree that I will participate in the planning of my child's care, treatment, or services, and that I may stop such care, treatment, or services that they receive through the undersigned counselor at any time. If I terminate services, I acknowledge that I am free to choose other agencies for treatment and that I may get a list of local referral resources from the counselor. Additionally, based on the judgment of the counselor, I may be referred to a source outside His Story Coaching and Counseling.

___ (Initial) I also understand that services may be terminated if I or the client become violent, verbally or physically aggressive, or act in a sexually inappropriate way toward other clients, guests, or staff at His Story Coaching and Counseling; if I or my child engage in illegal activity on Compass/His Story property; or if my child fails to attend three appointments without appropriate excuse.

By signing this Client Information and Consent form, I, the guardian of the 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.

Legal Guardian

_____Date_____

As witnessed by:

_____Date_____

His Story Coaching and Counseling
Notice of Privacy Practices
Client Consent Form

I understand that as part of my health care, the undersigned counselor originates and maintains health records describing my health history, symptoms, evaluations and test results, diagnosis, treatment, psychotherapy notes, and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other health care providers and other routine health care operations such as assessing quality and reviewing competence of health care professionals. I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been advised in the Notice of Privacy Practices that I have a right to copies of my entire file but acknowledge some information may not be in my best interest to review. In the event my counselor, in the exercise of his/her professional judgment, determines that information in my file may be injurious to me, I waive my right to obtain this information and release my counselor from any and all claims, damages, and causes of action that I suffer or could assert for his/her refusal to provide me with the information requested. The counselor's discretion shall control.

The Notice of Privacy Practices for this office provides specific information and a description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the Notice of Privacy Practices and have been given the opportunity to review the notice prior to signing this consent.

I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or health care any time in writing except to the extent that action has already been taken in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure of my personal health information.

_____

_____
Therapist response: Agree to restriction/ Do not agree to restriction

_____ Date: _____
Signature of Client or Legal Representative

_____ Date: _____
Signature of Client or Legal Representative

Witnessed: _____ Date: _____

COUNSELING INTAKE FORM - MINOR

His Story Coaching & Counseling

Client Information: Date: _____

Client Name(s)_____ Birth Date: _____

Grade: _____ Name of School:_____

Family Information:

Parent(s) _____

Parents' Occupations (M)_____ (F) _____

Current Employers (M) _____ (F) _____

Parent's relationship status: Please circle

Married Single Divorced Separated Widowed Living Together Never Married

****Please note****

If parents are divorced we must have a current decree on file before counseling begins

Siblings/ages

1. _____ Age _____ 3. _____ Age _____
2. _____ Age _____ 4. _____ Age _____

More _____

Current Living Arrangements:

_____

What is the family's religious preference?

_____

Is the minor currently active in their religion? Y N

Presenting Problem:

Please briefly describe the presenting problem or issue:

Current Stressors:

Please circle all that apply/list additional. Please provide a brief explanation.

family finance health school loss legal issues adjustment trauma peer issues

Symptoms:

If the minor has experienced a change in any of the following, please indicate an increase or a decrease by marking with arrows

sleep_____ appetite_____ energy_____ motivation_____ concentration_____

work_____ exercise_____ weight _____ anxiety_____ worry_____ stress_____

pleasure_____ anger_____ sadness_____ helplessness_____ depression_____

self-esteem_____ other_____

Please list any additional symptoms the minor has experienced in the last month:

Safety Issues:

Suicidal: Y N N/A Have you ever had any thoughts of suicide?_____

Previous Attempts/ Date _____

Plan/ Means _____

Homicidal: Y N N/A Risk: High Med Low

Previous Attempts/ Date _____

Plan/ Means _____

Self-Injury: Y N N/A Age Started: _____ Last S-I: _____ Method:_____

Personal History:

Has the minor experienced any emotional abuse? Y N

If Yes, Please describe:

_____
_____
_____
_____
_____

Has the minor ever experienced any sexual abuse? Y N

If Yes, Please describe:

_____
_____
_____
_____
_____

Has the minor ever experienced any physical abuse? Y N

If Yes, Please describe:

_____
_____
_____
_____
_____

If there has been abuse, has this been reported to CPS or the appropriate authorities? Y N

If yes, please provide the case number _____

Drug/Alcohol Exposure History: (includes use of marijuana and household chemicals)

Chemical	Amount	Frequency / Age Started	Last Usage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical History:

Date of last physical exam: _____

Results_____
_____
_____
_____

Any known Diagnoses? Y N List:

_____
_____

Any head injuries? Y N

If Yes, what type?_____ Date _____

Current Medications	Purpose	Date Started	Last Taken
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Psychiatric/Counseling Treatment History

Current/ Previous Therapist, Psychiatrist _____

_____

Reason_____Dates_____

Has the minor been hospitalized for a psychiatric reason? Y N

If yes, please explain:

_____

_____

Any Testing (psychological / neurological)? Y N

Test_____

Results_____

Any Known Psychiatric Diagnosis? Y N

If yes, please explain:

_____

_____

Birth History:

Prenatal Care: Y N

Pregnancy Complications:

_____

_____

_____

Type of Delivery: Natural C-Section

Delivery Complications:

_____
_____
_____
_____

What do you want to accomplish through counseling?

Is there anything else you want your counselor to know?

AUTHORIZATION FOR TREATMENT OF A MINOR

I certify that I have the legal right to authorize assessment and / or counseling for

_____.
(Child)

In any case in which there has been a divorce and / or custody dispute, the undersigned agrees to provide a copy of the court order identifying that person as having the legal authority to obtain counseling services.

I certify that I have read and understand the above information and that it is true to the best of my knowledge.

_____
Print name of legal guardian

_____
Signature of parent or caregiver who is the legal guardian

_____
Date

His Story Coaching & Counseling
Zoom Consent

I voluntarily consent to my child receiving counseling or coaching services through electronic media on the Zoom application. I understand that His Story takes all necessary HIPAA precautions to protect my child's information. However, I understand there are risks associated with using a teleweb service. I am consenting that I understand and am willing to have my child participate in counseling or coaching services online and waive His Story Coaching and Counseling and my child's counselor from any unintentional violation of my child's privacy.

I also understand that there may be technological issues that interrupt the session that are beyond the control of His Story Coaching and Counseling and my child's counselor. Should the session become disconnected, my child's counselor may suggest rescheduling the session to another time.

I also understand that the use of technology to facilitate counseling may impact the therapeutic relationship with my child's counselor, but I agree to discuss any concerns with my child's counselor.

Parent or Guardian

_____Date_____

As witnessed by (To be signed by Counselor):

_____Date_____