Forever Hope Counseling & Educational Services, LLC

Stone Oak Location
1162 E Sonterra Blvd Suite 130
San Antonio, Texas 78258

Alamo Heights Location
4900 Broadway Suite 500
San Antonio, TX 78209

www.foreverhopecounseling.com

COUNSELOR-CLIENT AGREEMENT AND CONSENT FORM

A few words about our counseling center:

Forever Hope Counseling is committed to providing the highest quality of services by using a multidisciplinary treatment approach. We believe every individual has the capability to succeed in improving their quality of life regardless of the nature of their conditions or life experiences.

During your initial consultation, our Clinical Director, Sandra Salazar, will assess the needs of you or your family member and will make the necessary clinical recommendations. She will also pair you with one of our trained therapists who best meets your needs to begin counseling services. Mrs. Salazar is a Nationally Licensed Professional Counselor, Certified Special Education teacher as well as a Certified School Counselor. She is a state approved Continuing Education Provider for LPCs and Certified Texas Educators. She serves the community as a public & private school district trainer, hospital and church mental health advisor and presenter. She also maintains a caseload as a psychotherapist and special education advocate. She has received extensive training in the diagnosing and treatment of: ADHD, Autism Spectrum Disorders, Learning Disabilities and Mood Disorders, Anxiety, Depression and Selective Mutism.

Forever Hope clinicians attend weekly clinicals to review and discuss case conceptualizations and participate in team collaborations.

Counseling Expectations:

Our clients are committed to begin services by attending weekly, then biweekly and will gradually move to monthly sessions. They develop healthy living strategies, learn coping & communication skills and to improve their overall personal growth. Our clients are active participants learning new ways to manage, resolve, or overcome their difficulties.

(**For minors**, parents are expected to attend "parent sessions" every 5th session of treatment to gain parental strategies and support from their child's therapist.)

Cancelled or Missed Appointments Fees:

We require a 24-hour cancellation notice of your appointment regardless of the reason for your absence. You will be charged a FULL rate for any same day cancellation or missed appointment. Messages can be left on our voicemail 24 hours prior to your appointment at 210-490-9062.

Same day cancellation charges include: absences due to same day illnesses, doctor appointments, vacations, extracurricular activities and other unavoidable obligations. *Initials* ____/____

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There is a **$50** returned check fee for any payment returned by your bank. ***Initials*** ____/____

PLEASE NOTE: All payments are due and payable at the guest counter upon check in BEFORE your session begin. Your credit card on file will be charged unless you inform the front desk you are prepared to pay by check or cash. You MUST pay at the time your services are rendered.

Counseling Services:	*New Consults – Licensed clinicians $175*	*Interns $100*
Counseling Support –	*Licensed Clinicians $100 - $175*	*Counseling Interns $80*
ABA Support -	*BCBA $125*	*ABA Skills Trainers $90*
Group Sessions -	*Licensed Clinicians $75/hr*	*Counseling Interns $50/hr*

Educational services:

Special Education Advocacy - **$225/hr** (This advocacy service is provided by our Clinical Director who is professionally licensed in school counseling and Texas Special Education certified)

Psychoeducational Testing:

Autism Spectrum Disorder, Dyslexia, Learning disabilities, ADHD - **$1895**

(Testing fee covers 4-6 hours of testing, testing results session, 504 Plan/IEP, advocacy campus visit, & test report with clinical & educational recommendations)

Court attendance and testimonies:

There is an **$800 (**4 hour) retainer fee for all court appearances. If the amount of time in court surpasses the prepaid (4 hour) retainer, you will be charged at the agreed upon $200/hour rate.

Additionally, if a subpoena is issued to your therapist for ANY legal matter related to you or your family member, you agree to accept and assume financial responsibility for the time preparing for ANY attorney's requests including but not limited to: *preparing the release of client records, any notarization costs, interviews, responding to ANY attorney's emails as well as phone calls at the $200 hourly rate.* ***Initials*** ____/____

Records and Confidentiality:

Your mental health record is accessible to you upon request. If you request a superbill (summary of receipts) or a copy of your records, there is a **$45 administrative charge for the first 20 pages and $1 per page thereafter**. This does not include postage and handling. You will be given receipt after each session or payment for your records. *Initials____/____*

There is also **a $45 administrative charge** for completion of forms by clinicians, request of payment history and any other duty considered administrative that requires less than an hour of the clinician's time to complete. *Anything that requires an hour or more will be charged a full rate for the clinician's time to complete the request.*

When a request is made directly from a government agency or official, there is NO charge.

Initials____/____

Electronic Communication:

We are committed to providing a safe, nonjudgmental and confidential therapeutic environment for you and your family. Please be aware that all communication via email, text messages, and other electronic means limit your privacy and will increase the chances of your personal information being shared with others.

Our clinicians are not permitted to communicate through email or text. Please leave a message for your therapist with our front desk or call to schedule a phone session if you are requesting to communicate with your therapist before your scheduled session.

Although our sessions may be very delicate in nature, both emotionally and psychologically, please keep in mind our relationship is professional rather than personal. All contact between us will be limited to paid sessions. *Please use your best judgment and reserve all calls for times you are unable to wait until your next session.*

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Termination of Services:

You may choose to end our counseling relationship at any point for any reason. We will be respectful of your decision to end our counseling relationship. You agree to actively participate in your sessions by coming to every scheduled appointment.

If you miss two consecutive sessions, your future appointments will be cancelled, terminated or you may be given a referral for a transfer to another therapist outside of our practice. Our clients share the responsibility for their treatment and are committed to attending their sessions consistently.

You agree to inform our office of any changes in child custody for the child/children related to our counseling services.

By signing below, you understand in the event that a request for your mental health records has been subpoenaed or made by either you or your spouse or significant other that is participating in counseling with you, you agree that an original copy of the records will be released and a copy of what was released will be sent to you and your spouse/partner by mail. You are also saying that you understand all costs and fees associated with the services we will be providing to you or your family. In addition, you are stating that your questions have been answered to your satisfaction.

Thank you for choosing to begin your care at *Forever Hope Counseling & Educational Services, LLC….*

_____ _____

Client Signature(s) Date

_____ _____

Client Signature(s) Date

_____ _____

Therapist Signature(s) Date

_____ _____

Clinical Director/Sandra Salazar, NCC, LPC Date

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PATIENT RIGHTS AND HIPPA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes". All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or a psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and are separate the rest of the individual's medical records. Excluded from "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from attached to release other medical records.

My signature indicates I have been offered a copy of Patient Rights and HIPAA Authorizations.

Signature: _____ Date: _____

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a client (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times or service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

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Debit/Credit Card Authorization Form

Forever Hope Counseling requires a credit card on file to secure services with our therapists. Please inform the front desk before your sessions begin if you have a preference to pay with cash or check; however, you must still provide a credit card for your file.

Name on the Card: _____

Type of Card: Visa ☐ MC ☐ Discover ☐

Card Number _____

Expiration Date _____

Security Code _____

Billing Address _____

City, State, Zip _____

Phone Number _____

E-mail Address _____

By signing this form, you authorize Forever Hope Counseling & Educational Services, LLC to charge this card for clinical, academic, or behavioral services provided for _____.
(Client Name)

This includes any fees related to these services, such as missed appointments or same day cancellations. If in the event your credit card is declined, or is not accepted by our credit card system, you agree to offer alternative credit card or to pay by cash or check until we have found a solution to your original preferred bank card.

We are unable to hold your appointments with your therapist if there is a balance on your account.

Cardholder Signature: _____ Date: _____

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Acknowledgement of Scheduled Appointments

Therapy sessions are given individualized treatment plans for each of our clients. For therapy to be most effective you must be an active and consistent participant. **It is our procedure to schedule weekly standing appointments in order to create stability and a foundation where change can occur.**

Here is our general flow of treatment that we follow:

Weekly sessions for the first 3rd-6th months

Biweekly sessions for the 6th-9th months

Monthly sessions for the 9th-12th months

We also request you to participate in parent sessions once a month to keep your child's therapy goals and progress on track. In some cases we may recommend individual sessions for parents in order to address issues we are unable to address during a parent session.

Please keep in mind we work together to determine the needs of each individual's situation and or conditions. Some clients take less time while others take longer to see results. A client's response to therapeutic intervention varies depending on many factors.

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ADULT INITIAL INTAKE FORM

Please note this information is treated as confidential. It is important that you are as accurate and truthful as possible. Thank you.

Today's Date: _____ Referred by: _____

Main area of concern: _____

Name: _____ Age: _____ DOB: _____

Address: _____

Marital status: ___Single ___Divorced ___Remarried ___Married ___Widowed ___Separated

Your Occupation: _____

work #_____ cell #_____

Spouse's name: _____ Age: _____

Your Spouse's Occupation: _____

work #_____ cell #_____

May we communicate through email? YES NO

If so, please list your email: _____

Emergency Contact: _____ cell # _____

Relationship to client: _____

Highest level of education: _____

Please list any prescription medications that you are currently taking: _____

_____

Previous Diagnosis: _____

1. Have you ever received counseling or psychiatric medications? YES NO
2. Previous therapist's name: _____
3. Previous therapist's phone number: _____

4. Prescribing physician's phone and address: _____

   _____

5. Please list all names and ages people living in your home:

   _____

   _____

6. Are there currently any significant life changes or stressful events that have occurred in the past two years such as marriage, divorce, new baby, financial instability, domestic violence, moving locations, new job…?

   _____

   _____

7. Have you ever received hospitalizations for the following reasons:

   ____ Physical illnesses: _____

   ____ Mental health illnesses: _____

   ____ Other reasons: _____

8. Are you currently involved in any pending court cases? YES NO

   If YES, please specify: _____

9. Have you ever committed a crime?

   If YES, please specify: _____

10. Have you ever had legal issues such as probation, divorce disputes, etc.? _____ yes _____ no

    Explain: _____

    _____

11. Have ever been physically violent or aggressive with others?

    If YES, please specify: _____

12. Do you own any weapons?

    If YES, please specify: _____

13. How satisfying are your current personal relationships?

Least 1 2 3 4 5 most

14. How satisfying are your current professional relationships?

Least 1 2 3 4 5 most

15. How many hours do you sleep each night? _____

16. What are your eating habits? Poor Good Excellent

17. How much exercise do you get per week? None 1-2hrs 3hrs+

18. Spiritual or faith beliefs: _____

Biological Family Mental Health History: (Please include yourself and distant relatives)

Condition	Please circle
Alcohol/Substance Abuse	Yes / No
Anxiety	Yes / No
Autism	Yes / No
Depression	Yes / No
Developmental Delays	Yes / No
Eating Disorders	Yes / No
Obsessive Compulsive Disorder	Yes / No
Schizophrenia	Yes / No
Suicide/suicide attempts	Yes / No
Odd/Bizarre behaviors	Yes / No

Other history:

1. Any experiences of abuse or neglect? ___ physical abuse ___ sexual abuse ___ verbal abuse

   Details: _____

   _____

2. How often do you drink alcohol:_____ never _____ 1-2 a week____ 3 or more times a week

3. Do you smoke? _____ never _____ 1-2 a week _____ 3 or more times a week
4. Do you engage in any recreational drugs? _____ yes _____ no
5. Have you ever experienced thoughts of hurting yourself or others? _____

   _____
6. Do you have a history of _____suicidal thoughts, _____plans or _____attempts?

   Please explain: _____
7. Have you ever experienced any form of auditory or visual hallucinations? _____

   _____
8. What do you consider to be your strengths? _____

   _____
9. What do you consider to be your weaknesses? _____

   _____
11. Do you experience stomachaches, headaches, or dizziness for an unknown reason? _____

    _____
12. Who do you consider your support system in your community or family? _____

    _____
13. Best memory of your childhood:

    _____

    _____
14. Worst memory of your childhood:

    _____

    _____

15. What would you like gain from therapy or what areas of concern would you like addressed in counseling sessions? _____

_____

_____

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To be completed by clinician during consultation ~ PLEASE DO NOT WRITE BELOW

Recommendations:

Frequency:	Weekly	Biweekly	Monthly	Consult Only	Referral
Type:	ABA	Skills training	Counseling	Diagnostic Testing	
Level:	BCBA	LPC-Intern/LMFT Associate/PsyD Intern		LPC/LMFT	Director

Special Notes:

Recommended clinician: _____

Date and time requested: _____

Other comments:

_____

_____

_____

_____

_____

Recommended Goals:

1. _____
2. _____
3. _____

_____ _____

Signature Date