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* ____/____

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

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

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 $175* *Interns $100*

Counseling Support – *Licensed Clinicians $100 - $175* *Interns $80*

There is also **an hourly charge ($80-$175)** for clinicians to complete forms for you.

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. In some instances, one parent or one individual in couple's counseling may request a copy of the family/couple's records. **A fee of $45.00 will be charged for the first 25 pages of the record and additional pages will be at a rate of $1.00 per page.** When one member of the couple or one of the parents requests a copy of the record, the other parent/individual in couple's counseling will also be offered a copy of the record at an additional cost of $45.00 for the first 25 pages and $1.00 for each additional page. This does not include postage and handling. You will be given a receipt after each session or payment for your records. 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.

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

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 you and your therapist 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.*

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

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

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

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

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.

Client Name: _____

Signature: _____ Date: _____

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

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: _____

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

CHILD INITIAL INTAKE FORM

Please provide the following for your child. 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: _____

Child's name: _____ Age: _____ DOB: _____

Do you have the right to bring your child in for counseling?: YES NO

Address where child lives: _____

Who does the child live with? ___mother ___father ___both ____stepmother _____stepfather

Parent Name: _____ DOB: _____

Specify if: __biological __step __guardian

Occupation: _____ Place of Employment: _____

work #_____ cell #_____

Parent Name: _____ DOB: _____

Specify if: __biological __step __guardian

Occupation: _____ Place of Employment: _____

work #_____ cell #_____

May we communicate through email? YES NO

Preferred Email: _____

Emergency Contact: _____ cell #_____

Relationship to client: _____

Who lives in your household? _____

_____

Are there siblings? Please list names, ages and gender: _____

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 400
San Antonio, TX 78209

www.foreverhopecounseling.com

Who is your child's Pediatrician?: _____

Date of last visit: _____

Phone Number: _____

Address: _____

MEDICAL BACKGROUND:

1. Has your child received any type of mental health services (psychotherapy, counseling, medication, psychiatric services)? ___No ____Yes: Please list: _____
2. Name of previous therapist: _____ Phone:_____
3. Was previous counseling successful? _____
4. Is your child currently taking any medications? ____No ____Yes
5. Prescribing Physician's name and number: _____

   If yes, please list name(s) and milligrams:
   _____

   _____

   Any previous medications? ____No ____Yes

   If yes, please list name(s) and milligrams:
   _____

   _____

   About how long has your child been on these medications? _____
6. Does your child complain of pains, stomach aches, headaches, tiredness? _____

   Please explain: _____

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 400
San Antonio, TX 78209

www.foreverhopecounseling.com

DEVELOPMENTAL MILESTONES:

1. Eating: ___bottle fed ___breast fed
2. Sat up at _____
3. Sleeping habits _____
4. Crawled at _____
5. Walked at _____
6. Smiled at _____
7. Used complete sentences _____
8. Learned to ride a bike _____

Childhood Illnesses: _____

Surgeries: _____

Injuries: _____

PREGNANCY:

Is this child your: Biological child _____ Adopted child _____ Foster child _____

Was your child a planned pregnancy? Yes/No Natural or C-Section? Weeks of gestation _____

Please list any delivery complications: _____

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

Condition	Please circle	Paternal	Maternal
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		

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 400
San Antonio, TX 78209

www.foreverhopecounseling.com

EDUCATION BACKGROUND:

1. What school is your child attending? _____ Grade:_____
2. Has your child ever had to repeat a grade? If so, which grade? _____
3. Has your child ever been suspended or expelled from school? If so, which grade? _____

   If so, please elaborate: _____

   _____
4. Has your child ever been recommended or received special education services? If so, what grades? _____
5. Does your child currently have an IEP from his/her school? _____
6. Does your child currently have a 504 Plan at school? _____
7. Describe the main focus of your child's IEP or 504 Plan (note any accommodations your child is currently receiving or please provide a copy of the IEP/504). _____

   _____

   _____
8. Please inform us of your child's schooling history:

Schooling Level	Name of School	Grade(s) Attended
Day Care		
Elementary School		
Middle School		
High School		

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 400
San Antonio, TX 78209

www.foreverhopecounseling.com

PLEASE CHECK ANY OF THE FOLLOWING RELATED SERVICES:

_____ IEP _____504 _____ SPEECH _____OT

SOCIAL AND PEER DEVELOPMENT SILLS:

1. Is your child struggling in school?____no _____yes: which subject(s)? _____
2. On average how long does it take your child to finish homework? _____
3. Does your child "play" outside? _____
4. How much time does your child spend on video games in a week? _____ hours
5. What game ratings do you allow your child to play? _____
6. Does your child use the internet without supervision? _____
7. What safeguards are you taking regarding explicit exposures to harmful exposures?

   _____
8. Does your child seem to enjoy things other children their age enjoy? _____
9. Does your child have repetitive behaviors or strict rituals they focus on daily? _____

   _____
10. Does your child have difficulty making friends? _____
11. How many friends would you say your child has? _____
12. Does your child have difficulty communicating or socializing with others?

    _____
13. Is he or she heavily interested in a particular topic or activity? _____

    _____
14. What chores does your child have? _____
15. Has your child ever imposed self-injury? _____

_____ SI_____ HI _____ AH _____ VH ; Explain:_____

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 400
San Antonio, TX 78209

www.foreverhopecounseling.com

PARENTING:

1. In a few sentences, please describe your relationship with your child. _____

   _____

   _____

2. What are your methods of discipline regarding your child?

   ___ grounding ___ spanking ___ lectures ___ yelling ___ take away privileges ___ other

   _____

   Are you open and willing to learn new effective strategies in handling difficult behaviors? _____

3. Has your child <u>ever</u> been cruel to animals? _____No _____Yes
   Details:_____

   _____

4. What is your family's faith or spiritual belief? _____

5. Would you like prayer to be incorporated in your child's sessions? __yes __no __I don't know

6. What do you consider to be your strengths as a parent? _____

   _____

   _____

7. What do you consider to be your weaknesses as a parent? _____

   _____

   _____

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

   _____

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

   _____

10. Are there 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 school…?

_____

_____

ABUSE:

1. Any experiences of abuse or neglect? ___physical abuse ___sexual abuse ____ verbal abuse

   Details: _____

   _____

2. What would you like your child to gain from therapy or what areas would you like addressed in sessions?

   _____

   _____

   _____

Please explain any other details you would like to share: _____

_____

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 400
San Antonio, TX 78209

www.foreverhopecounseling.com

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: _____ Next appt: _____

Date and time requested: _____ Clinician: _____

Other comments:

_____
_____
_____
_____
_____

Recommended Goals:

1. _____
2. _____
3. _____

_____ _____

Signature Date