Forever Hope Counseling & Educational Services, LLC
Stone Oak Location
1162 E Sonterra Blvd Suite 130
San Antonio, Texas 78258
Boerne Location
108 Oak Park
Boerne, TX 78006
www.foreverhopecounseling.com

# COUNSELOR-CLIENT AGREEMENT AND CONSENT FORM

## *A few words about our counseling center:*

Forever Hope Counseling is committed to provide 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 your needs and will offer clinical recommendations. She will also select a trained therapist on our team who best meets your needs to begin counseling services. In some cases, appropriate diagnostic testing will be recommended to better understand your needs.

It is important for you to know that Forever Hope clinicians attend weekly clinical staff meetings to review, discuss and participate in team collaborations and case conceptualizations to better assist you.

## *Counseling Expectations:*

Our clients begin services weekly basis. After your needs are showing awareness, improvement or positive change, the frequency of your appointments, are scheduled on a bimonthly basis. During the final stages of your treatment or therapy, your sessions will be scheduled to monthly sessions.

Clients, who are ready to end treatment, develop healthy living strategies, learn coping & communication skills and to improve their personal growth. They are active participants learning new ways to manage, resolve, or overcome their difficulties.

## *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*** _____/_____

## *Minors:*

**Parent sessions are considered a form of counseling. These parent sessions are a time to share updates with your therapist and it provides a time for your therapist to provide feedback. Typically, these family or parent appointments are scheduled every 5th session or as frequently as necessary. Parents are expected to attend these sessions to gain parental strategies and provide insight to their child's therapist. Parents are not allowed to "drop off their children". A responsible adult must be present to speak to the therapist should the therapist need to speak to you. You must inform our office of any changes in child custody for the child/children related to our counseling services.**

***All payments are due and payable BEFORE your session begins. Your credit card on file will be charged unless you inform the office in advance that you prefer to pay by check or cash.***

***Counseling Services:***

*New Consultations – $185 (Licensed Professionals) $100 (Interns)*

*Counseling Sessions – $125 - $185 (Licensed Professionals). $90 (Interns)*

*We charge full rates for our clinicians to complete forms or letters for you.*

*Session overages are charged $50 per every 15 minutes over the 50 minute session time.*

***Educational services:***

$225/hr (This advocacy service is provided by our Clinical Director who is a Licensed Professional Counselor Supervisor, Certified School Counselor and Texas Special Education Teacher)

***Psychoeducational Testing:***

$1895 - ADHD, Autism Spectrum Disorder, Dyslexia, Learning Disabilities
*Your testing fee covers 4-6 hours of testing, testing results session, 504 Plan/IEP, advocacy campus visit, & test report with diagnosis (when applicable), clinical & educational recommendations.*

***Court attendance and testimonies:***

There is an **$800 retainer fee** for all court appearances. If the amount of time in court surpasses the prepaid 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.

**Our clinicians are NOT permitted to communicate by phone, text or email.** Please leave a message for your therapist with our front desk or call to schedule a phone 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.

**If you miss 3 consecutive sessions, your future appointments will be cancelled and 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.

*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-S | 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:

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**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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## .HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEATLH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

**Effective date: July 8, 2014**

Forever Hope Counseling & Educational Services, LLC will only release information in accordance with state and federal laws and the ethics of the counseling profession.

This notice describes Forever Hope Counseling & Educational Services, LLC's policies related to the use and disclosure of the client's healthcare information. **Use and disclosure of protected health information for the purposes of providing services.** Providing treatment services, collecting payment, and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

**TREATMENT:**

- Provide, manage, coordinate care with other healthcare professionals.
    - 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.

1. 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.

2. ***Special Instructions for completing the 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.

My signature indicates I understand HIPAA Authorizations and a separate mental health information disclosure form must be signed to grant permission to discuss protected client information.

Client Name: _____

Signature:_____ 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 ☐

**American Express is not accepted*

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 _____.** This card will be charged for 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 schedule appointments with your therapist if there is a balance on your account.

Cardholder Signature:_____Date: _____

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# Informed Consent for Teletherapy Services

The following information is provided to clients who are seeking Teletherapy services. This document covers your rights, risks and benefits associated with receiving services, my policies, and your authorization. Please read this document carefully, note any questions you would like to discuss before you agree to sign.

**Teletherapy Services Defined:**
Teletherapy Services means the remote delivering of any form of counseling services via technology-assisted media. This includes a wide array of clinical services and various forms of technology that include, but is not limited to, video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video conferencing is the preferred method of service delivery.

**Limitations of Teletherapy Services:**
While Teletherapy Services offer several advantages such as convenience and flexibility, it is an alternative form of therapy, or adjunct to therapy, and thus may involve disadvantages and limitations. *For example, there may be a disruption to the service (e.g. phone gets cut off or video drops).* This can be frustrating and interrupt the normal flow of personal interaction.

Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. *For example, if video quality is lacking for some reason, your counselor might not see various details such as facial expressions. Or if audio quality is lacking, they might not hear differences in your tone of voice that they could easily pick up if you were in their office.*

Additionally, your therapist's office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. Your therapist will take every precaution to ensure technologically secure and environmentally private sessions.

**Interactive Video, Electronic Medical Record, Secure Email for Documents: *Forever Hope Counseling* uses JITUZU and or Doxy.me for interactive video, which complies with HIPAA standards requiring 256-bit AES encryption.**

**Client Responsibilities for Teletherapy Services:**

1. The virtual sessions can only be conducted while the client is within the state of TEXAS.
2. The virtual sessions must be conducted on a Wi-Fi or ethernet (not mobile) network for the best connections and to minimize disruption.
3. Only communicate through a device that you know is safe and technologically secure (e.g. has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.) Do not use "auto-remember" names and passwords.
4. If you conduct a Teletherapy session at your place of employment, make sure you have checked your company's policy before using a work computer for personal communication.
5. As the client, you are responsible for finding a private, quiet location where the sessions may be conducted.
6. Sessions are not able to take place if other individuals are present in your location.
7. Your therapist is required to verify your identity and location at the start of each session.

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**In Case of Technology Failure:**
Teletherapy sessions could encounter a technological failure. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. *If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, PLEASE call the office at (210) 490-9062.* You must have access to the phone that your therapist has so you can be reached. In addition, your session may need to be rescheduled, if there are problems with connectivity.

**I AGREE TO THE FOLLOWING:**

_____**I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location.** I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversations.

_____**I understand that there will be no recording of any of the online sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.**

**Consent for Teletherapy Services Treatment:**

_____**I voluntarily agree to receive online therapy, parent, couples or family therapy services including an assessment, continued care, treatment, and/or other services and furthermore authorize FOREVER HOPE COUNSELING & EDUCATIONAL SERVICES, LLC** to provide such care, treatment or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive at any time. By signing this Informed Consent, I, the undersigned 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.

_____ Date_____
Patient/Client Signature

_____
Parent/Guardian/Legal Representative Signature
(if minor or needed otherwise)

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# 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 ☐ step-mother ☐ step-father

Parent Name: _____ DOB:_____

Specify if: ☐ biological ☐ step ☐ guardian ☐ adoptive

Occupation: _____ Place of Employment: _____

Work #:_____ Cell #:_____

Parent Name: _____ DOB:_____

Specify if: ☐ biological ☐ step ☐ guardian ☐ adoptive

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, & gender: _____

_____

Who is your child's Pediatrician?: _____
Date of last visit: _____
Phone Number: _____
Address: _____

**MEDICAL BACKGROUND**

1. Has your child ever received any type of mental health services? (psychotherapy, counseling, medication, psychiatric services)? ☐ No ☐ Yes If yes, please list: _____
2. Name of previous therapist: _____ Phone #:_____
3. Was previous counseling successful? _____
4. Is your child currently taking any medications? ☐ No ☐ Yes
    a. If yes, please list medication(s) and millgram(s):

        _____
        _____
        _____

    b. About how long has your child been on these medications? _____
5. Prescribing Physician's name & number: _____
6. Does your child complain of pains, stomach aches, headaches, tiredness?: ☐ No ☐ Yes
    a. If yes, please explain: _____

**DEVELOPMENTAL MILESTONES: (To the best of your memory, please estimate when your child reached these milestones.)**

1. Eating: ☐ bottle fed or ☐ 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: _____

Allergies: _____

Injuries: _____

**PREGNANCY:**

Is this child your: ☐ biological child ☐ adopted child ☐ foster child

Was your child a planned pregnancy? ☐ Yes ☐ No Weeks of gestation: _____

Natural or C-Section? _____

Please list any delivery complications: _____

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

| Condition | Please check | | |
|---|---|---|---|
| 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, Schizoaffective | ☐ | Yes / No | ☐ |
| Suicide/suicide attempts | ☐ | Yes / No | ☐ |
| Odd/Bizarre behaviors | ☐ | Yes / No | ☐ |
| Other | ☐ | Yes / No | ☐ |

**EDUCATION BACKGROUND:**

1. What school is your child attending?: _____ Grade: _____
2. Has your child ever had to repeat a grade? If so, which grade(s)?: _____
3. Has your child ever been suspended or expelled from school? ☐ Yes ☐ No
   a. If so, which grade(s)?: _____
   b. Please elaborate: _____
   _____
4. Has your child ever been recommended or received special education services? ☐ Yes ☐ No
   a. If so, which grade(s)?: _____
5. Does your child currently have an IEP or 504 from his/her school? ☐ Yes ☐ No
6. 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).: _____
   _____
   _____

7. 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** | | |

**PLEASE CHECK ANY OF THE FOLLOWING RELATED SERVICES:**
☐ IEP ☐ 504 ☐ SPEECH ☐ OT ☐ PT

**SOCIAL AND PEER DEVELOPMENT SKILLS:**

1. Is your child struggling academically or behaviorally in school?: ☐ No ☐ Yes

   If yes, please explain: _____

2. On average how long does it take your child to finish homework?: _____
3. Does your child spend time outdoors?: _____
4. How much time does your child spend on electronics in a week? _____ hours
5. What game ratings do you allow your child to play?: _____
6. Does your child use the internet without supervision?: ☐ No ☐ Yes
7. What safeguards are you taking regarding explicit exposures to harmful exposures?:

   _____

8. What chores does your child have?: _____
9. How many friends would you say your child has?: _____
10. Does your child have difficulty making friends? ☐ No ☐ Yes

11. Does your child have difficulty communicating or socializing with others?: _____

_____

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

_____

13. Does your child seem to enjoy things other children their age enjoy?: ☐ No ☐ Yes
14. Does your child have repetitive behaviors or strict rituals they focus on daily? ☐ No ☐ Yes
    If yes, please explain: _____
15. Has your child ever imposed self-injury? ☐ No ☐ Yes
    If yes, please explain: ☐ SI ☐ HI ☐ AH ☐ VH : _____

_____

**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
3. Are you open and willing to learn new and effective strategies in handling difficult behaviors?
   ☐ Yes ☐ No
4. Has your child ever been cruel to animals? ☐ No ☐ Yes
   If yes, please explain: _____
5. What is your family's faith or spiritual belief?: _____
6. Would you like prayer to be incorporated in your child's sessions? ☐ Yes ☐ No ☐ I don't know
7. What do you consider to be your strengths as a parent?: _____

_____

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

_____

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

_____

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

_____

11. 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 your child to gain from therapy or what areas would you like to be addressed in sessions? _____

   _____

   _____

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

_____

_____

_____

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**This page is to be completed by the clinician during initial consultation.**

**Recommendations:**

| | | | | |
|---|---|---|---|---|
| Frequency: | Weekly | Biweekly | Monthly | Consult Only |
| Type: | Family Therapy | Skills Training | Counseling | Diagnostic Testing |
| Level: | LPC/LMFT/LCDC | LPC-Intern/LMFT-Associate/PsyD Intern | | Director / PhD |

**Other comments:**

_____

_____

_____

_____

Accepted _____ Denied _____ Referred to: _____

**Recommended Goals:**

1. _____
2. _____
3. _____

**Special Notes:**

Recommended Clinician: _____

Meet & Greet date and time: _____

Date and time requested: _____

Rate: _____

_____ _____

Signature Date