Carolyn Sidereas, M.S., L.P.C.-S.
Casey Christian, L.C.S.W.
Brent Theis, M.A., L.P.C.-S.
Nancy Bourland, M.S., L.P.C.
Tammy Smith, M.A., L.P.C.
Malia Nompone, M.S., L.P.C.
Steve Johnson, M.A., L.P.C.
Kimberly West, M.S., L.P.C.
Andrea Crumrine, M.A., L.P.C.
Lourie Ferrell, M.S., L.P.C.
David Foster M.A., D. Min. L.P.C.
Amy Perkins, M.S., L.P.C. Intern
Supervised by Carolyn Sidereas, L.P.C.-S

LAKE POINTE COUNSELING CENTER
Confidential Child/Adolescent Intake Information

Date _____

Child's Name:_____ **Age**:_____ **Date of Birth**:_____

PARENT Name:_____ **Address**:_____ May we contact using:
City/State/Zip:_____ **Cell Phone/Text**: _____ ☐yes no
E-mail:_____ ☐yes no
Your Relationship to Child:_____

OTHER PARENT (not step) Name:_____ **Address**:_____ May we contact using:
City/State/Zip:_____ **Cell Phone/Text**:_____ ☐yes no
E-mail:_____ ☐yes no

Are the parents of the child divorced? ☐ Yes ☐ **No**

Please list any additional siblings:

1.	***Age:***	***Step:*** ☐yes no	***Adopted?*** ☐yes no	***Gender:*** ☐male female
2.	***Age:***	***Step:*** ☐yes no	***Adopted?*** ☐yes no	***Gender:*** ☐male female
3.	***Age:***	***Step:*** ☐yes no	***Adopted?*** ☐yes no	***Gender:*** ☐male female
4.	***Age:***	***Step:*** ☐yes no	***Adopted?*** ☐yes no	***Gender:*** ☐male female
5.	***Age:***	***Step:*** ☐yes no	***Adopted?*** ☐yes no	***Gender:*** ☐male female

Step Parent Name: _____ **Phone:** _____

Emergency Contact Name:_____ **Relationship**_____
Address:_____ **City/State/Zip**:_____
Phone:_____ **E-mail**:_____
Referred by: _____

Do you currently have a church home? ☐Yes ☐ No **Are you a member of Lake Pointe Church?** ☐ Yes ☐ No

If the minor client is named in a custody agreement or court order, you shall give the treating provider a **FULL COPY** of the **MOST RECENT CUSTODY AGREEMENT** and/or **COURT ORDER**, as well as any **DIVORCE DECREE**. The **minor cannot be seen** until we have a copy of that paperwork. It will be maintained in the minor clients file. It is the responsibility of the parent to provide **any and all** updated documents should it occur during the time of treatment. Initials: _____ Other Parents Initials: _____

Your Signatures Below:
I have read and understand the Patient Services Agreement of Lake Pointe Counseling Center.

_____
Client Signature

_____
Signature of Parents/Legal Guardian if Client under 18 years of age (must have both parents' signature if applicable)

_____
Signature of other Parent (if participating in therapy)

PATIENT SERVICES AGREEMENT

GENERAL INFORMATION: This Agreement contains information about privacy and patient rights. As required by law, your Notice of Privacy Practices for use and disclosure of Private Health Information (PHI) is available from our office. The law requires that we obtain your signature acknowledging that you were provided this information. Your signature represents a revocable agreement between us. A written revocation will be binding on us unless Lake Pointe Counseling has taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

MENTAL HEALTH SERVICES: The nature of psychotherapy varies depending on the personalities of the therapist and patient. In order for the therapy to be successful, you will have to work on things talked about both during sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. Growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. One might hope this would balance out with the discovery of joy relief and freedom as well. Benefits of psychotherapy include better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience. Your therapist will evaluate your needs and offer treatment recommendations. You can discuss any questions you may have. If you have persistent doubts, your therapist will help you get a second opinion.

COUNSELING RELATIONSHIP: Your relationship with any therapist is a professional and therapeutic one. It is imperative that your therapist does not have any other type of relationship with you. Personal and/or business endeavors undermine the effectiveness of the therapeutic relationship. Your therapist cares about helping you but is not in a position to have a social, personal, or business relationship with you of any kind.

EMERGENCY CALLS: After business hours, we provide an answering machine on which you can leave a message for return calls. We will make every attempt to return your call within 24 hours with the exception of weekends and holidays. If you feel that you can't wait for a return call, contact your family physician, 911, or the nearest hospital emergency room. It is not Lake Pointe Counseling Center's policy to text, email or do phone sessions with clients. If you choose to do so, you waive your right to confidentiality.
Initial:_____ Initials: _____

CONFIDENTIALITY: Confidentiality is defined as keeping private the information shared by you, the client, and your therapist. As a client, you have the right to withhold or release information to other individuals or agencies. No information will be released to anyone not preforming business for this office without your consent unless mandated by Texas law. You may request an accounting of all disclosures made of your record, and, whenever it is possible, any disclosure of your healthcare information to an outside individual or agency will be discussed with you prior to disclosure. Please be advised that, although protecting your confidentiality is a priority for your therapist, Texas law mandates several exceptions to your right to confidentiality.

LIMITS ON CONFIDENTIALITY: The law protects communications between a patient and a mental health provider. Typically, information about your treatment is only released to others if you sign a written authorization form. This signed Patient Services Agreement provides consent for the following:
• Your therapist may need to consult other professionals about a case. Every effort is made to avoid revealing the identity of patients. The other professionals are also legally bound to keep the information confidential. If you don't object, you will not be told about these consultations unless your therapist feels that it is important to your work together.
• Your therapist practices with other mental health professionals and Lake Pointe Counseling employs administrative staff. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member or signed consent of patient.
• Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.
• If a patient seriously threatens to harm himself/herself, your doctor or therapist may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. There are some situations where your therapist may disclose information without either your consent or authorization:

• If you are involved in a court proceeding and a request is made for information concerning your treatment, such information is protected by law. Your therapist cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
• If a government agency requests information for health oversight activities, we may be required to provide it.
• If a patient files a complaint or lawsuit against a therapist of Lake Pointe Counseling, your therapist may disclose relevant information regarding that patient for the purpose of legal defense
• If a patient files a worker's compensation claim, your therapist must, upon request, provide records relating to treatment or hospitalization for which compensation is being sought.

There are some unusual situations in which your therapist is legally obligated to take actions necessary to protect others from harm and may have to reveal some information about a patient's treatment.
• If your therapist believes that a child has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, a report must be made to the appropriate governmental agency. Your therapist may then be required to provide additional information.
• If a therapist believes that the patient will inflict imminent physical, mental, or emotional harm upon himself/herself, or others, the therapist may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient. If such a situation arises, or therapist will make every effort to discuss it with you before taking any action and will limit disclosure to what is necessary.

If you have questions regarding confidentiality, you should bring them to the attention of your therapist and discuss this matter further. Please be advised that by signing this information and consent form, you are giving your consent to the therapist to share confidential information with all persons mandated by law, and you are releasing and holding harmless the therapist from any departure from your right of confidentiality that may result.
Initials: _____ **Initials: _____**

CLIENT RECORDS: Protected Health Information (PHI) about you is kept in two sets of records. (1)Your Clinical Record includes information about your reasons for seeking therapy, your diagnosis, treatment goals, medications, your progress, your medical and social history, your treatment history, any past treatment records received from other providers, reports of professional consultations, billing records, and reports that have been sent to anyone, including reports to insurance carriers. Typically, you may examine and/or receive a copy of your Clinical Record, you have a right of review.
(2) Psychotherapy Notes assist your therapist in providing treatment. They contain the sensitive information that you may reveal. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. You may examine and/or receive a copy of your Psychotherapy Notes unless your therapist determines that release would be harmful to your physical, mental or emotional health.

PATIENT RIGHTS: You have some rights regarding your Protected Health Information including requesting that your therapist amend your record; requesting restrictions on what is disclosed to others; requesting an accounting of most disclosures of protected health information that you have not authorized; determining the location to which protected information disclosures are sent; having complaints about your therapist's policies and procedures recorded in your records; and a paper copy of this Patient Services Agreement, the attached Notice form, and our privacy policies and procedures.

MINORS & PARENTS: The law allows parents to examine a minor child's treatment records unless the treatment is for suicide prevention, chemical addiction, or sexual, physical or emotional abuse. Because privacy is often crucial to success, your therapist will typically provide parents only with general information the child's treatment. Before giving parents any additional information, the therapist will discuss the matter with the child.

PAYMENT FOR SERVICES: Payment is due at the time services are rendered, after each session. The fee is $100 per session. Lake Pointe Counseling Center accepts cash, checks and most credit cards. Fees incurred for returned checks are the client's full responsibility.
Initials:_____ Initials: _____

INSURANCE: Lake Pointe Counseling Center does not bill insurance, nor are we in network with any insurance companies. We can provide a statement for you containing CPT and a diagnosis code. This statement may be submitted by the client to insurance carriers for reimbursement should the carrier accept out of network claims. Clients are responsible for all charges whether or not they are covered by insurance.
Initials:_____ Initials: _____

ADDITIONAL SERVICES/ADDITIONAL COSTS: Although it is the goal of the therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. In the event disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records. If your therapist is requested or mandated to prepare and give testimony in legal proceedings, you must pay for all the professional time as indicated: court fee $500 for a half day paid seven (7) days in advance of the court proceeding; each additional hour to appear in legal proceeding is $200; each additional hour of preparation time is $100; and reimbursement for transportation and parking costs.
Initials:_____ Initials: _____

REPORT PREPARATION FEES: We do not fill out paperwork for FMLA, Short-Term Disability, Long-Term Disability, Worker's Compensations claims, or write letters for Emotional Support Animal requests. These types of requests should be filled out specifically **by your medical doctor**. This paperwork requires a medical diagnosis from a medical doctor. Counseling services do not serve as a substitute or bypass medical care that is required for these certain types of documents to be completed.

CANCELLATION FEE: Therapy appointments are usually 45 minutes in length. Your therapy time is reserved for you. *Please call to cancel or reschedule at least 24 hours in advance*. If 24 hours notice is not given or a "no show" occurs, *you will be charged a customary $100 fee* for the missed appointment. Insurance does not cover charges for missed sessions.
Initials:_____ Initials: _____

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE HAD THE OPPORTUNITY TO READ AND RECEIVE A COPY OF THE HIPAA PRIVACY NOTICE DESCRIBED ABOVE.

A copy of this document is available upon your request or accessible at www.lakepointe.org . Date: ____-____-____
Client or Parent/Guardian **SIGNATURE**: _____ **SIGNATURE**: _____
If the patient is under age or has a guardian appointed by the court, this agreement must be signed by the patient's legal guardian. If the agreement is signed by a personal representative of the patient, a legal description of such representative's authority to act for the patient must be provided.

Date _____

LIFE FUNCTIONING INVENTORY

This form is intended to help your counselor become better acquainted with your child and in turn, serve you better. Please print the information requested or checkmark the appropriate responses. You may omit any item but try to be as thorough as possible. Thank you. Form Completed By: _____

Please list the problem(s) with which you want help: _____
_____
_____

How long has this been a problem? _____
_____

How has this been a problem? _____
_____

Has your child had previous counseling or other psychological treatment(s)? □yes□ no If so, where and when was this received? For what problems? _____
_____
_____

What strategies have been used at home to address these problems?

verbal reprimands	avoiding the child	removal of privileges
time-out	yelling	giving in
physical punishment	rewards	communication

Over which of the following issues (if any) do you have regular conflict?

room cleaning	dating relationships	choice of friends
curfew	household chores	other _____
music	clothes/appearance	

Do you consider yourself (and your spouse) consistent in your disciplining?

most of the time	some of the time	none of the time

Do you and your spouse have any consistent differences in your approach to discipline or expectations of your child? □yes no □n/a

Family Information:
Please list any previous mental health history of any family members: _____
_____

Briefly describe your child's relationship with other members of your household: _____
_____
_____

Medical History:
Has your child had any of the following:
head injury what age? _____ loss of consciousness due to head injury? yes no
surgery for what? _____
broken bones describe: _____
severe injury describe: _____
Medications list: _____

Is your child having any difficulty with appetite or eating habits? yes no If yes, check where applicable:
eating more eating less binge eating restricting calories significant weight change (in past two months)

Has your child ever been hospitalized for psychiatric reasons? □yes □no
If yes, please specify the following: Reason for hospitalization: _____
Hospital location: _____
Dates of hospitalization: _____
Duration of hospitalization: _____

Has your child had suicidal thoughts recently? □yes □no How often? □daily □weekly □monthly □rarely
Have they had them in the past? □yes □no How often? □daily □weekly □monthly □rarely

Has your child ever intentionally inflicted harm upon themselves? □yes □no
How often? □daily □weekly □monthly □rarely Nature of harm: _____

Academic History:
School currently attending: _____ Grade: _____
Grades (check all that apply):

Most recent report card:	□ A's	□ B's	□ C's	□ D's	□ F's
Typical grade performance:	□A's	□ B's	□ C's	□ D's	□ F's

Has your child ever had an individual, educational assessment? □yes no
If yes, where, when, and what were the results? _____
_____
_____

Check any of the following learning problems that have been identified:

ADD/ADHD	Dyslexia	Reading Disorder
Math Disorder	Written Expression Disorder	Other: _____

How easily does he/she make friends?

better than average	average	worse than average

Does your child have a best friend? □yes no Friends how long? _____
On average, how long does your child keep friendships?

less than six months	one year	more than a year

Miscellaneous:
Please list any major changes in your child's life over the past five years: _____
_____
_____
_____
_____

Is there anything else you want me to know about your child? _____
_____
_____
_____

Thank you for completing this paperwork. I look forward to meeting with your child and discussing all of this and more.

_____
Client Signature

_____
Signature of Parents/Legal Guardian if Client under 18 years of age (must have both parents' signature if applicable)

_____
Signature of other Parent (if participating in therapy)

Lake Pointe Church Counseling Center
No Child Custody Testimony Agreement

I, _____, the parent, guardian or personal representative of the minor child, _____, agree not to call to court, subpoena or otherwise engage the treating mental health professional (therapist, provider), _____ in any legal proceedings regarding child custody. I also agree to instruct any counsel representing me in any issue regarding child custody not to call to court, subpoena or otherwise engage the treating mental health professional in any legal proceedings regarding child custody.

I understand that the purpose of the treatment of my child is to address concerns of mental and/or behavioral health, and that it is important for my child to have a therapeutic sanctuary where feelings and thoughts can be expressed freely. I understand the importance of the trust my child establishes in the therapist and in the process. I understand that the involvement of the mental health professional in court would break this trust, forcing the exposure of private thoughts and feelings into a public record against the will of my child and the therapist. I further understand that forcing testimony would not be in the best interest of my child and could be likely to undermine future psychotherapy or counseling/testing that may be necessary in the future.

I understand that **counselors in Texas are legally prohibited from offering professional opinions regarding child custody unless a formal child custody evaluation has been performed according to specific guidelines (Texas Family Code 104.008)**. A counselor cannot be both a treating psychologist and an evaluator for purposes of custody. I understand that there are several forensic psychologists available in the area and that these psychologists may be engaged to provide an independent evaluation for court purposes.

_____ _____
Parent, guardian or personal representative Date

_____ _____
Parent, guardian or personal representative Date

Lake Pointe Church Counseling Center
HIPPA – Notice of Privacy Policies

This notice describes how your private health information may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Private Health Information may be used and disclosed in the following circumstances:

1. When required by any state or federal law, including case of abuse and neglect.
2. When required for any specialized government or military functions including active personnel, reservists, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
3. When used for any clerical purposes and necessary chart audits by managed care companies.
4. In accordance to Texas Health & Safety Code, Chapter 611, records of release protocol.

As a client, you have rights to your Private Health Information, including:

1. The right to review your records or receive a copy of your records at any time by signing a formalized, written request. However, under certain rare circumstances your request can be denied. Written requests for records will be honored within 15 days after receiving a proper written request that has been filed with Lake Pointe Counseling Center.
2. The right to request information of any party that has requested information pertaining to your Private Health Information.
3. The right to receive confidential information regarding your private health information.
4. The right to revoke this consent in writing; however, this will not affect any information already disclosed.

Lake Pointe Counseling Center has the responsibility to:

1. Make you, the client, aware of the Lake Pointe Counseling Center Privacy Policies which is available on our website or we have available copies upon request at our office.
2. To make the necessary changes to the Privacy Notice that are required by law.
3. If you as the client feel your privacy has been violated, you have the right to contact the US Department of Health & Human Services Office of Civil Rights at www.hhs.gov/ocr/hipaa/. Or, you may file a complaint to the Texas State Board of Examiners of Professional Counselors in Austin, Texas. Main Numbers: 512-776-7111 or 1-888-963-7111.

I have reviewed and understood this notice.

Client: _____

Client signature: _____

Today's Date: _____