

METROPLEX COUNSELING

A Center For Biblical Soul Care

209 N. Industrial Blvd,
Bedford, TX 76021

2591 Dallas Parkway #300
Frisco, TX 75034

817-571-4110
www.metroplexcounseling.com

SECTION ONE: COUNSELEE INFORMATION:

Client Name _____ Spouse Name _____

Date of Birth: _____ Age: _____ Sex: M F (Circle One)

Marital Status (please circle) Married Separated Divorced None

Children (names/ages) _____

Occupation _____ Employer _____

Home Address _____

City _____ State _____ Zip _____

Home Phone () _____ Cell () _____

Work Phone: () _____

Home email address _____

Please check any of the following at which you prefer NOT to be contacted

Work Phone () Spouse Phone () Work email () Your cell ()

Emergency contact name and phone # _____

SECTION TWO: CANCELLATION POLICY

Your appointment time is reserved exclusively for you. It is the policy of Metroplex Counseling, Inc. to charge a full session fee for all appointments for which you do not show up or for which cancellation is not made within 24 hours of your scheduled appointment.

Missed or canceled appointment fees will be assessed at the regular rate on this credit card.

Visa () Mastercard () Discover () American Express ()

Credit Card Number _____ Exp. Date _____

Name as it appears on credit card _____

I agree to this policy as stated above and authorize that the credit card named above will be charged at the full session hourly rate. Initial here: _____

SECTION THREE: CHURCH AFFILIATION

1. Are you a member of a local church? Yes No (Circle One)
2. If so, what is the name and location of the church? _____

3. If so, how long have you attended this church? _____
4. Are you actively involved in your church? Yes No (Circle One)
5. Do you have a person/people to whom you are accountable at your church? Yes No (Circle One)
6. Do you believe being an active part of a community of believes is important to reaching your goals in counseling? Why? Why Not?

SECTION FOUR: REFERRAL

Please provide the information below regarding who referred you to Metroplex Counseling. May we send them a card extending our appreciation for their trust in our services?

Yes No (Circle One)

Name: _____ Email: _____

Address: _____ Phone: _____

Church/Ministry Affiliation: _____

SECTION FIVE: Preliminary Assessment

1. Please check all the following that apply to you at this time:

- | | |
|---|---|
| <input type="checkbox"/> I feel depressed | <input type="checkbox"/> I feel anxious |
| <input type="checkbox"/> I feel hopeless | <input type="checkbox"/> I feel fearful |
| <input type="checkbox"/> I feel angry | <input type="checkbox"/> I struggle with anger |
| <input type="checkbox"/> I feel sad | <input type="checkbox"/> I think of suicide |
| <input type="checkbox"/> I struggle with bitterness | <input type="checkbox"/> I feel worthless |
| <input type="checkbox"/> I am having marital problems | <input type="checkbox"/> I struggle with my in-laws |
| <input type="checkbox"/> I have children | <input type="checkbox"/> I struggle as a parent |

- | | |
|---|---|
| <input type="checkbox"/> I abuse alcohol | <input type="checkbox"/> I use illegal drugs |
| <input type="checkbox"/> I use prescription drugs | <input type="checkbox"/> I abuse prescription drugs |
| <input type="checkbox"/> I view pornography | <input type="checkbox"/> I struggle sexually |
| <input type="checkbox"/> I have committed adultery | <input type="checkbox"/> My spouse has committed adultery |
| <input type="checkbox"/> My spouse is a poor communicator | <input type="checkbox"/> I am a poor communicator |
| <input type="checkbox"/> I do not attend church regularly | <input type="checkbox"/> I do not read my Bible often |
| <input type="checkbox"/> Jesus is important in my life | <input type="checkbox"/> I don't think about Jesus much |
| <input type="checkbox"/> I strongly fear rejection | <input type="checkbox"/> I have been sexually abused |
| <input type="checkbox"/> I have been physically abused | <input type="checkbox"/> I have been verbally abused |
| <input type="checkbox"/> I have been sexually abusive | <input type="checkbox"/> I have been physically abusive |

2. Briefly describe why you have chosen to seek counseling:

3. What do you hope to achieve throughout the counseling process?

SECTION FIVE: CLIENT RIGHTS AND RESPONSIBILITIES/INFORMED CONSENT

In an effort to make informed decisions about your counseling experience, the following paragraphs are provided in order to discuss pertinent information regarding your counselor’s background and qualifications as well as your rights and responsibilities as a client. If you have any questions or concerns as it relates to the following information, please feel free to express them.

COUNSELOR (check the name of your counselor):

___ Jeremy Lelek, M.A., Ph.D. Candidate, L.P.C.

___ Steve Clay, M.A., L.P.C.

___ Scott Lowrey, M.Ed., L.P.C.-Intern

___ Allison Threlkeld, M.Ed., L.P.C.-Intern

___ Katie Hummel, M.Ed., L.P.C.-Intern

LICENSURE:

Your counselor holds either a license or a temporary license in the State of Texas to provide counseling services. Under this license, he or she practices under the authority of the Texas LPC licensing board, and therefore must adhere to the board’s ethical guidelines. If you have a complaint regarding the services provided by your counselor, you have the right to file a grievance with the following agency:

Texas State Board of Examiners of Professional Counselors
1100 West 49th Street
Austin, TX 78756
512-834-6658

METHOD OF COUNSELING:

Your counselor’s method of counseling is based on biblical principles. He/she is a Christian counselor, which means that he/she believes Jesus Christ is the son of God, and that by trusting in His atoning death, anyone may have life in his name (John 5:24). While your counselor’s beliefs impact and shape the counseling process, he/she is able to work with those who do not share his/her beliefs.

GOALS, RISKS, AND BENEFITS:

There is always a risk of emotional side effects from counseling. Sometimes symptoms worsen before they get better. Often counseling brings up painful emotions. Our goal is to confront these issues and emotions together in order to work through them in a timely manner. Other types of counseling, such as support groups may also be appropriate in your situation. Together we will determine if one or more types of counseling are indicated and/or appropriate.

LENGTH OF COUNSELING:

Length of counseling is very difficult to predict. Each individual and marriage has unique strengths and weaknesses, and each problem is different from the next. The goal is that each client will finish counseling in a timely manner, without unnecessary waste of time and money.

FEES:

Counseling sessions will be 50 minutes long. Together with your counselor, decisions concerning how often and how long you should come will be discussed. Each session will cost \$_____. Personal checks or credit card are acceptable for payment. In many cases insurance will reimburse you for all or part of this fee. We do not file insurance claims for you. You must do this on your own. However, appropriate documentation for you to give you insurance company will be provided at your request. Payment is due in full the day of service. I understand the above named counselor has the right to withhold further counseling if I do not financially meet the obligation payment as cited above.

OUR RELATIONSHIP:

The relationship between you and your counselor is professional rather than personal in nature. It is important to keep the parameters of this relationship clear, therefore personal phone calls and social interaction are inappropriate. Please do not offer gifts, ask for written references, or expect to relate in any way other than in the professional context. Service is best provided if counseling sessions concentrate exclusively on your concerns.

RIGHT TO PRIVACY: Initial here: _____

All communication between the client and counselor becomes part of the clinical record. Records are the property of Metroplex Counseling. In accordance with legal requirements, adult client records may be disposed of seven years after the file is closed; minor client records are disposed of seven years after the client's 18th birthday.

While most communication between a client and counselor is confidential, the following limitations and expectations do exist:

- Case records may be utilized for purposes of supervision, professional development, and research. In such cases, to preserve confidentiality, clients are identified by first name only.
- The counselor determines if the client is a danger to himself or someone else.
- The client discloses abuse, neglect, or exploitation of a child, the elderly, or a disabled person.
- The client discloses sexual contact with another mental health professional.
- The client authorizes the counselor to release records.
- The counselor is ordered by a court to disclose information.
- The counselor is otherwise required by law to disclose the information.

In the case of marriage or family counseling, there is limited confidentiality, ***meaning that confidentiality belongs to the relationship and not to the individual.*** When expedient the counselor will share with the counselee the intent to notify relatives or authorities before the above actions are taken.

SUPERVISION:

The staff of Metroplex Counseling operates as a team to improve the quality of counseling we offer. Your counseling may be discussed with your counselor’s clinical supervisor, center director, and other counselors at Metroplex Counseling (during group supervision). Such discussions will remain confidential. Names will only be shared with the director or clinical supervisor on an as needed basis. Tape or video recording may be made of your counseling sessions for professional training purposes only. This will be done only with your knowledge and permission. Your counselor will discuss this with you.

REFERRALS:

Should the client and/or counselor believe that a referral is needed, alternatives will be provided. A verbal exploration of alternatives to counseling will also be made available upon request. The client will be responsible for contacting and evaluating those referrals and/or alternatives.

CONSENT FOR COUNSELING MINORS:

I, _____ (guardian name), represent that I have legal authority to obtain counseling for any minor child/children.

EMERGENCIES:

During office hours, the client can contact the counselor at 817-571-4110. If the client is unable to reach his counselor in a timely manner, he/she should contact a physician, a local emergency room or the local police department when necessary and appropriate (dialing 911). It is the client’s responsibility to seek the appropriate resources in emergency situations.

By your signature below, you indicate that you have read and understood this statement, and any questions about this statement were answered to your satisfaction. A copy of this completed form will be provided to you at your request. By your counselor’s signature, _____ (counselor name) verifies the accuracy of this statement and acknowledges his/her commitment to conform to its specifications.

Client/Guardian Signature: _____ Printed Name: _____

Date: _____

Counselor Signature: _____ Printed Name: _____

Date: _____

METROPLEX COUNSELING:

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make a new Notice available upon request.

USES & DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

1. We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes. To help clarify these terms, here are some definitions:

- “*PHI*” refers to information in your health record that could identify you.
- “*Treatment, Payment and Health Care Operations*”
 - *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or other practitioner.
 - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- “*Use*” applies only to activities within The Center for Christian Counseling, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of The Center for Christian Counseling, such as releasing, transferring, or providing access to information about you to other parties.

2. We may disclose to a family member, other relative, a close personal friend of yours, or any other person identified by you, the health information directly relevant to such person’s involvement with your care or payment related to your health care.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission that is above and beyond the general consent that permits only specific disclosures. In those instances, when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your counseling notes. “*Counseling notes*” are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or counseling notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

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USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Texas Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against us with the State Board of Examiners, the board has the authority to subpoena confidential mental health information from us relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

PATIENT RIGHTS

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described previously). On your request, we will discuss with you the details of the accounting process.

QUESTIONS OR COMPLAINTS

For more information about our privacy policy or have questions or concerns, please contact us. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may complain to us using the contact information listed at the end of this Notice. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will provide you with that address to file your complaint upon request.

Contact Officer: Jeremy Lelek
Telephone: 817-571-4110
Address: 209 N. Industrial Blvd. #237
Bedford, TX 76021

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**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY
PRACTICES**

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Signature

Date

Signature

Date

For office use only

We attempted to obtain written acknowledgement of receipt of Notice of Privacy
Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Specify below)
- _____
