Steve Barns & Associates
The Counseling Center
of Denton Bible Church
Christian Counseling Services
Individual, Marriage, & Family

DENTON BIBLE CHURCH

Phone: (940) 297-6893
Fax: (940) 387-3009
counseling@dentonbible.org
2121 Nottingham Drive
Denton, Texas 76209

Adult Intake Form

Counselee Name: _____ _____ _____
Last First MI

□ Male □ Female ____/____/____ _____
Date of Birth Age

Email:_____@_____ Home: (___) ____-_____ Cell: (___) ____-_____

Address: _____ _____
Street (or P.O. Box) Apt. #

_____ _____ _____
City State Zip Code

Place of Employment: _____ How long? ____ yrs. ____ mos.

Emergency contact: _____ (___) ____-_____

How did you hear about us? _____.

Current Marital Status

□ Never married □ Engaged □ Separated (___ yrs. ___ mos.) □ Divorced (___ yrs. ___ mos.)

□ Married (___ yrs. ___ mos.) Spouse's name: _____ ____/____/____ _____
Date of Birth Age

Previous Marriages

Self ___ time(s) Date(s) ____ /____ -- ____ / ____, ____ /____ -- ____ / ____, ____ /____ -- ____ / ____

Spouse ___ time(s) Date(s) ____ /____ -- ____ / ____, ____ /____ -- ___ / ____, ___ /____ -- ____ / ____

Military Information

□ Active duty □ Reserve □ Separated from service □ Tricare insurance (if so, provide information below)

DOD # _____ Branch of service _____ Division of Tricare (North, South, Reserve, etc.) _____

Claims address: _____
Street (or P.O. Box)

_____ _____ _____
City State Zip Code

Children

Together: □ T Self: □ S Spouse: □ Sp

□ T □ S □ Sp _____ Age ____ □ M □ F □ Biological □ Adopted □ Foster

□ T □ S □ Sp _____ Age ____ □ M □ F □ Biological □ Adopted □ Foster

□ T □ S □ Sp _____ Age ____ □ M □ F □ Biological □ Adopted □ Foster

□ T □ S □ Sp _____ Age ____ □ M □ F □ Biological □ Adopted □ Foster

□ T □ S □ Sp _____ Age ____ □ M □ F □ Biological □ Adopted □ Foster

□ T □ S □ Sp _____ Age ____ □ M □ F □ Biological □ Adopted □ Foster

□ T □ S □ Sp _____ Age ____ □ M □ F □ Biological □ Adopted □ Foster

_____ ____/____/____
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Religious Affiliation

You do not have to be a Christian to receive counseling here. We take your personal beliefs very seriously and will always respect them. We want you to feel free to express your values and beliefs and how they affect the way you live. While we will always respect your beliefs we may encourage you to consider what we believe to be biblical truths that, if applied to your life, will help you live a more fulfilling, meaningful life. We may introduce ideas during our conversations that will encourage you to change how you are living in ways that will be enriching to you and those around you.

I attend church at _____. Attended since: ____ /____

Member since: ____ /____ I attend: □ Every Sunday □ Most Sundays □ Occasionally

My spouse attends with me □ Every Sunday □ Most Sundays □ Occasionally □ Never

Would you like to receive counseling from a biblical perspective? □ Yes □ No

If you are a Christian, how would you describe your relationship with God? _____

_____

_____.

Personal Information

For what specifically are you seeking counseling today? _____

_____

_____.

What recent event(s) prompted you to seek counseling? _____

_____

_____.

What ongoing problem(s) has (have) contributed to you seeking counseling? _____

_____

_____.

Describe any losses you have experienced in the past two years (family members, job, spouse, etc.).

_____

_____.

What are your expectations in coming here? _____

_____

_____.

Describe yourself as a person. _____

_____

_____

_____.

_____ ____ /____ /____
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Do you sleep well? □ Yes □ No

How many hours do you typically sleep? _____

When do you typically go to bed? _____

When do you typically wake up? _____

Have your eating habits changed recently? □ Yes □ No If so, please explain. _____

_____

_____.

Have you gained or lost ten pounds or more over the past year? □ Yes □ No If so, please explain.

_____

_____.

Do you have eating problems (bingeing, overeating, purging, etc.)? □ Yes □ No If so, please explain.

_____

_____.

Have you had difficulty with employment recently or in the past? □ Yes □ No If so, please explain.

_____

_____.

Have you ever been convicted of a felony? □ Yes □ No If so, please explain. _____

_____

_____.

Describe your usage (or abuse) of the following:

Alcohol _____

Caffeine _____

Tobacco _____

Marijuana _____

Prescription medication _____

Share anything else you believe may be helpful for you and your counselor. _____

_____

_____

_____

_____.

_____ _____/_____/_____
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Medical Information

How would you characterize your physical health? □ Excellent □ Good □ Fair □ Poor

Who is your physician? _____ Do you see him/her □ Regularly □ As needed

List any medical problems you currently have. _____

_____

_____.

List any medications you currently take for physical problems. _____

_____

_____.

Have you ever been hospitalized for medical reasons? □ Yes □ No If so, please explain. _____

_____

_____.

Mental Health Information

Are you currently under the care of a mental health professional (psychiatrist, psychologist, counselor)?
□ Yes □ No
If so, who? _____

Have you received counseling or psychiatric care in the past? □ Yes □ No

When? _____/_____ For how long? ____ yrs. ____ mos.

From whom? _____

For what reason? _____.

Have you ever been given a mental health diagnosis by a mental health professional? □ Yes □ No

If so, what was the diagnosis? _____.

Do you believe the diagnosis was accurate? □ Yes □ No Why or why not? _____

_____

_____.

List any medications you currently take for diagnosed psychiatric issues or for other mental health reasons (depression, anxiety, etc.). _____.

Have you ever been hospitalized for mental health reasons? □ Yes □ No If so, please explain. _____

_____

_____.

_____ ____/____/____
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Have you ever attempted suicide? □ Yes □ No If so, how many times? _____

When? ____ /____ , ____ /____ , ____ /____

By what means? _____.

Have you ever physically harmed another person? □ Yes □ No

Is there a history of suicide in your immediate or extended family? □ Yes □ No

Are you presently having thoughts of harming yourself or someone else? □ Yes □ No

Have you had any recent memory loss? □ Yes □ No

Please describe any of the following that apply to members of your family.

Drug or alcohol abuse: _____

_____

_____.

Physical, verbal, or sexual abuse: _____

_____

_____.

Mental health issues (depression, anxiety, bi-polar disorder, etc.): _____

_____

_____.

Other issues about your family that you believe may be relevant and helpful for you and your counselor:

_____

_____

_____.

_____ ____ /____ /____
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Notice of Privacy Practices

This notice describes how 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 laws 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 took 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 and Disclosures for Treatment, Payment, and Healthcare Operations

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

PHI refers to information in your health record that could identify you.

Treatment is when we provide, coordinate, or manage your healthcare and other services related to your healthcare. An example of treatment would be when we consult with another healthcare provider, such as your family physician or other practitioner.

Payment is when we obtain financial compensation for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your healthcare or to determine eligibility or coverage.

Healthcare Operations are activities that relate to the performance and operation of our practice. Examples of healthcare 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 Steve Barns & Associates, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

Disclosure applies to activities outside of Steve Barns & Associates, such as releasing, transferring, or providing access to information about you to other parties. We may disclose to a family member, other relative, a close personal friend, or any other person identified by you, the health information that is directly relevant to such person's involvement with your care or payment related to your healthcare.

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.

Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and healthcare 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 healthcare operations, we will obtain an authorization from you before releasing this information. We will also obtain a separate authorization before releasing your counseling notes.

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) 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 without Consent or 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 some other 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, your personal or legally appointed representative, or a court order. The privilege does not apply when you are being psychologically 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 and/or obtain a copy 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 given authorization (as described previously). On your request, we will discuss with you the details of the accounting process.

_____ _____ /_____ /_____
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Questions or Complaints

For more information about our privacy policy, or if you 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 given below. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Should you wish to contact the Texas State Board of Examiners of Professional Counselors, the address is: Complaints Management and Investigative Section, P.O. Box 141369, Austin, TX 78714-1369.

Office Manager: Meg Hamilton
Email: counseling@dentonbible.org
Phone: 940-297-6893
Fax: 940-387-3009
Physical address: 2121 Nottingham Dr., Denton, Texas, 76209
Mailing address: 2300 E. University Dr., Denton, Texas, 76209

Acknowledgement of Receipt of Privacy Practices

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

_____ _____ /_____ /_____
Signature Date

For office use only

We attempted to obtain written acknowledgement of receipt of our 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)_____

_____ _____ /_____ /_____
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Fees

We offer several options regarding our fees. The fee will vary, depending on the certification and experience level of your counselor. Some counselors can file on your insurance. Some of our counselors offer a sliding scale as a way of making counseling more affordable for all who need it. The office manager will go over the options with you at the time of your first session.

The following is our current fee structure:

Steve Barns, LPC-S, LMFT————Sliding scale, some insurance
Mary Winter, LPC————————Sliding scale, some insurance
Alex Kelley, Biblical Counselor———$45.00/session
Randy Nickerson, LPC————————Sliding scale, some insurance
Ashley Davis, LPC————————Sliding scale
Bonny Pierce, CTPSC————————$45.00/session
All Lay Biblical Counselors————No charge

Sliding Scale

Gross Family Income	*Fee*	
$65,000 or more	$85	□
$50,000-$64,999	$75	□
$40,000-$49,999	$65	□
$30,000-$39,999	$55	□
$0-$29,999	$45	□

Please indicate what the appropriate fee would be for you, based on your family income.

Timely Payment

Payment is typically made at the time of the session. We accept cash, checks, and debit or credit cards. If you have concerns or unanswered questions your counselor will be glad to spend time discussing the fee structure with you. Often payment arrangements can be made if the cost represents a difficulty for you.

Insurance

If you are covered by insurance, please contact your insurance provider to determine whether or not your counselor is a network provider and to verify benefits. If your counselor is out of network, we will provide a receipt upon request so that you may file for reimbursement.

Cancellation of Appointments

Due to scheduling demands, we require a 24 hour notice to cancel or reschedule a session. Because we understand that emergencies do occur, whether or not you are charged for insufficient notice will be at the discretion of your counselor.

Informed Consent

I understand issues may be discussed during counseling that could be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand records and information collected about me will be held and released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require my therapist to report all cases in which there exists a danger to others or myself, such as suspected abuse or neglect of minors or vulnerable adults.

I understand there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand if I have a managed care insurance plan that offers reimbursement for counseling services, I must indicate that at the time I complete my initial paperwork and call my insurance company to authorize therapy sessions. If I am out of network, I understand it is my responsibility to file for reimbursement. Steve Barns & Associates will supply a receipt that will have the information needed to process the claim.

I agree to pay my counseling fees in a timely manner as arranged at the time of my first session. Should a third party other than insurance agree to pay for my sessions, I agree to allow Steve Barns & Associates to release billing information to the third party.

I have read and understand the above terms and conditions of my treatment and agree to the content of this document.

_____ ____ /____ /____
Signature Date

_____ _____ /_____ /_____
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Health insurance information

Fill out only if you have insurance that will pay for counseling.

Name of insured _____

_____ _____ _____
Street or P.O. Box City State, Zip

Counselee's relationship to the insured: □ Self □ Spouse □ Child □ Other _____

Insured's birth date: ____ /____ /____ Insured's SS #: _____-_____-_____

Insured's ID #: _____ Group #: _____

Insured's phone: (____) _____-_____ Insured's email: _____@_____

Insured's employer: _____

Insurance company: _____

Claim form address: _____ _____ _____
Street or P.O. Box City State, Zip

Insurance company phone: (____) _____ _____

Deductible amount to be met: $_____.

Co-pay amount per session: $_____.

Provide the following information to your insurance company:

Provider's name:
Steven Barns, LPC, LMFT, or Robert Steven Barns, LPC, LMFT
2300 E. University Dr.
Denton, TX 76209

Billing CPT codes (if requested):
Initial visit—90791
Subsequent visits—90834

Authorization to release information to process claims

I hereby authorize direct payment of mental health benefits to Steve Barns & Associates for services rendered through this office.

I understand that I will be financially responsible for any balance not covered by insurance.

I □ do □ do not want my primary care physician notified.

Physician: _____

Address: _____ _____ _____
Street or P.O. Box City State, Zip

_____ _____ /_____ /_____
Signature Date

_____ _____ /_____ /_____
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Health insurance information

Fill out only if you have insurance that will pay for counseling.

Name of insured _____

_____ _____ _____
Street or P.O. Box City State, Zip

Counselee's relationship to the insured: □ Self □ Spouse □ Child □ Other _____

Insured's birth date: ____ /____ /____ Insured's SS #: _____-_____-_____

Insured's ID #: _____ Group #: _____

Insured's phone: (____) _____-_____ Insured's email: _____@_____

Insured's employer: _____

Insurance company: _____

Claim form address: _____ _____ _____
Street or P.O. Box City State, Zip

Insurance company phone: (____) _____ _____

Deductible amount to be met: $_____.

Co-pay amount per session: $_____.

Provide the following information to your insurance company:

Provider's name:
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I understand that I will be financially responsible for any balance not covered by insurance.

I □ do □ do not want my primary care physician notified.

Physician: _____

Address: _____ _____ _____
Street or P.O. Box City State, Zip

_____ _____ /_____ /_____
Signature Date

_____ _____ /_____ /_____
Counselee Name Today's Date