Welcome to New Horizon Counseling Services

Client Information and Informed Consent for Services

Welcome and thank you for choosing New Horizon for your counseling services. Today's appointment will take approximately 50 minutes after you have completed the forms. We realize that beginning a process of counseling may be a major decision, and that you may have many questions. This document is intended to inform you of our policies, your rights, and state and federal laws. If you have any questions or concerns, please ask and we will try our best to give you all the information you need. When you sign this document, it will represent an agreement between you and New Horizon Counseling Center (NHCC).

Our Counseling Center

New Horizon is dedicated to providing the highest quality in our respective areas of expertise to our community. Our mission is to promote a positive emotional and psychological lifestyle for our clients through counseling and psychotherapy services.

Our Therapists

Our therapists are graduates from a major accredited University, holding a Master's degree in Counseling or higher. Each therapist is licensed through their respective Texas State Board. Those that are interns are in the process of completing 3,000 supervised hours; they are under supervision to ensure that you will receive the highest excellence of service. New Horizon carefully selects interns based on their knowledge, character, ethics, experience, and passion to help.

If you have any questions, concerns, or complaints you may ask to speak with the Clinical Director of NHCC

If you have any complaints, you may contact the Complaints Management and Investigative Section
PO Box 141369, Austin, Texas 78714-1369
Website: http://www.dshs.state.tx.us/
Telephone: 1-800-942-5540

_____
Initials

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and the client as well as the particular problems you bring forward. There are many different methods your therapist may use to deal with the problems that you hope to resolve. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our 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 like sadness, guilt, anger, frustration, loneliness, and helplessness. Psychotherapy has also shown to have great benefits for people who go through the process. Therapy often leads to an improved relationship, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about procedures, they should be discussed whenever they arise. If your doubts persist, your therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.

Sessions

Normally an evaluation will be conducted that will last at least two sessions. During this time, you and the therapist both decide whether your therapist is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy has begun, we will usually schedule one 50-60 minute session per week or as needed. Once an appointment is scheduled, you will be expected to pay for it unless you provide a 24-hour advance notice of cancellation or reschedule (unless we agree that you were unable to attend due to circumstances beyond your control.)

Confidentiality & Limitations

All communication with your counselor is confidential and will not, except under circumstances explained below, be disclosed to anyone outside of New Horizon unless you give written authorization to release information. You will need to sign a Release of Information Form if you wish to have New Horizon staff communicate information to anyone other than those specified below (see Consent for Limited Release of Information).

A record is kept of your work with us. It contains information you have provided to us in writing as well as counseling notes of your sessions. The record remains at New Horizon for a period of seven years following your last visit; at that time, it is destroyed. **Your record never leaves the Counseling Center.**

It is important that you understand that all identifying information about your therapeutic treatment is kept confidential. Information solicited by phone, written, or in person about clients will not be provided. You will need to sign the Consent to Release Information Form before any information is provided to a third party outside our office. This condition applies also in

cases where coordination of treatment is necessary with another health professional (physician or psychiatrist). However, there are exceptions and/or limitations to confidentiality. The following are limitations to confidentiality:

- In cases of immediate risk/threat of suicide or homicide on the part of the client.
- In cases of child or elderly sexual abuse or neglect
- In cases required by law.

I have received or offered a copy of the HIPAA Notice of Privacy Practices and fully understand how my personal health information will be used and disclosed. _____ **Initials**

Emergency Contact

We are usually available Monday through Friday from 9:00 am to 7:00pm. If we are not able to answer the phone, you can leave a message in our voicemail with your name and phone number where we can reach you. We will make every effort to return your call on the same day you made it, with the exception of weekends and holidays. If you are not able to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency hospital. If we will be unavailable for an extended time, we will provide you with point of contact if necessary.

Requested Services (Please check all that may apply)

Individual Counseling: ___ Marriage/Couples Counseling: ____ Family Counseling: ___ EAP: ____

Please note all indicated below will have certain requirements / restrictions:

Immigration Assessments: ____ Disability Assessments ____ (fees applies)

Professional Fees & Fee Agreement

Insurance: _____ Member ID #: _____

Primary Insurance Holder: _____ Group ID #: _____

DOB of Primary Insurance Holder _____/_____/_____ Relationship: _____

The following is a fee agreement between NHCC & _____.
Clt Name (& Ins Name, if applicable)

I will be expected to pay $_____ for each session at the beginning of my session. _____ **Initials**

I understand that in the event my insurance provider does not pay for any of my attended session(s), I will be fully responsible for the entire amount billed to the insurance provider _____ **Initials**

I understand that my appointment time is reserved exclusively for me and if I don't cancel or reschedule my appointment with at least a 24hr advance notice, I will be responsible for a $25 fee. _____ **Initials**

I understand that if I request any documents (copies, letter, assessment, & etc) there is an administrative fee and is to be paid in full prior to receiving the requested documents. I understand I am responsible for the fees and that it is NOT covered by insurance. _____ **Initials**

CONSENT TO TREATMENT

By signing this Client Information and Consent Form as the client or Guardian of said client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment treatment and services for me, and I understand that I may stop such treatment or services at any time.

_____ _____

Signature – Client Date

_____ _____

Signature – Therapist Date

DO NOT FILL BELOW LINE - STAFF ONLY

Attending Support Staff: _____

Uploaded By: _____ Date: _____

NEW HORIZON COUNSELING CENTER
Adult Personal Information

Name_____Date_____

Address_____Apt_____

City _____ State _____ZipCode_____

E-mail _____OK to contact? □YES □NO

Home Phone _____ OK to contact? □ YES □ NO

Cell Phone _____ OK to contact? □ YES □ NO

Date of Birth _____/_____/_____ Age _____ Gender: □ Male □ Female

Employer_____Occupation_____

Number of different jobs in past 3 years: _____ Last Grade / School Completed_____

Social Security #: _____-_____-_____

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

If married, separated, divorced, or widowed, how long: _____

Name of Spouse/Partner_____Date of Birth ___/____/_____

Have Children: □ Yes □ No If yes, how many children? _____

Name of Children/Others in Household	Relationship	Date of Birth	Age	Lives with You
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No

Physician Name _____Date of last physical: ____/____/_____

Would you like to give your therapist permission correspond your physician Yes / No

Are you taking medication(s): □Yes □ No If yes, what type? _____

_____

Any health issues: _____

_____

In Case of Emergency:

I authorize to contact _____Relationship_____

Phone Number _____ Alternate Phone Number: _____

How did you hear about us? ☐ Friend/Family ☐ Former/Current Client ☐ Psychology Today

☐ Our Website ☐ Goodtherapy.com ☐ Counsel-search.com ☐ Other:_____

NHCC ASSESSMENT and HISTORY INFORMATION

This information will help you and your therapist begin to clarify your therapy goals.

Patient Name: _____ Date: _____

□ Yes □ No Have you ever been treated by a psychiatrist?

If yes, Name _____ Phone # _____

□ Yes □ No I give permission to my therapist to correspond with indicated psychiatrist above

□ Yes □ No Have you ever been hospitalized for mental or chemical dependency treatment?

If yes, please indicate month/year and location(s)_____

□ Yes □ No Have you seen another therapist in the past 24 months?

If yes, who did you see? _____

□ Yes □ No Have you ever attempted suicide?

If yes, when? _____

Briefly describe your reason for seeking counseling services: _____

_____

_____

What kind of things have you tried so far to handle this situation? _____

_____

_____

Please place a number that best corresponds to the issue listed below: (rate those that apply)

NEVER RARELY SOMETIMES OFTEN ALWAYS

0 1 2 3 4 5 6 7 8 9 10

___Abuse – physical
___Abuse – sexual
___Abuse – emotional
___Abuse – neglect
___Aggression, violence
___Alcohol use
___Anger, hostility, irritable
___Anxiety, nervousness
___Attention distraction
___Career concerns, goals, choices
___Co-dependence
___Confusion
___Compulsions
___Cruelty to animals'
___Crying, sadness
___Custody of children
___Decision-making, indecision
___Delusions (false ideas)
___Depression
___Divorce, separation
___Drug Use (prescribed)
___Drug Use (illegal)
___Eating problems
___Financial
___Gambling
___Grieving
___Goals
___Guilt
___Headaches
___Impulsiveness
___Judgment
___Loss of control
___Marital/Partner
___Memory problems
___Menstrual, PMS, menopause
___Mood swings
___Obsession/compulsion
___Panic/Anxiety attacks
___Parenting
___PTSD
___School problems
___Self-esteem
___Sexual issues
___Sleep problems
___Stress
___Suicidal thoughts
___Tobacco use
___Temper/low tolerance
___Thought disorganization
___Work problems
___Other:_____

NHCC ASSESMENT and HISTORY INFORMATION Cont.

In the past 36 months has there been a death of a family member or someone close to you?

□Yes□ No If yes, who? _____ When: _____

Prior to the 36 months, has there been a death of someone that was close to you?

□Yes□ No If yes, who? _____ When: _____

Please rate below on a scale of 1 to 10, 1 = not at all, and a 10 = very much so:

____ I am/was very close and have/had a good relationship with my father.

_____ I am/was very close and have/had a good relationship with my mother.

_____ I am/was very close and have/had a good relationship with my siblings.

_____ I have good friends.

_____ I am physically active

_____ I eat healthy

_____ I drink at least 5 glasses of 8 ounces of water a day

_____ I sleep at least 6 hours per night

_____ I have a hobby(s)

_____ I have nightmares.

_____ I enjoy spending time alone.

_____ I have a tendency of agreeing with other people to avoid confrontations.

_____ I don't like being around other people, I want to be alone.

_____ I feel good about myself.

_____ I have a healthy interest in sex.

_____ I sometimes am confused with my identity.

_____ I put the needs and wishes of others first before myself even if I am not comfortable with it.

_____ I think I am responsible for the way others feel and their behaviors

_____ I drink alcoholic beverages at least 3 times per week.

_____ I have a problem saying "no"

_____ Others can make me mad, frustrated, disappointed, or sad easily.

Fears or concerns of counseling: _____

_____

Goal or expectation of counseling: _____

_____

Current Symptoms of Issue_____

_____