Welcome to New Horizon Counseling Services (Teen / Child)

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: ___ Teen / Child Counseling:___

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 – Parent / Legal Guardian Date

____ ____________________________
Signature – Therapist Date

DO NOT FILL BELOW LINE - STAFF ONLY

Attending Support Staff: ____

Uploaded By: ____ Date: __________________________

NEW HORIZON COUNSELING CENTER
Child Registration

Child's Name: ____ Date: ____________

Child's Address: ____ Apt: _______________

City: ____ State: ______ Zip Code: __________

Child's Race: ___________________Gender: M ~ F DOB: _____/_____/________ Age ___

Father's Name: _________________________________ DOB: _____/_____/________ Age ___

Father's Employer: ______________________________ Occupation: ______________________

Mother's Name: _________________________________ DOB: _____/_____/________ Age ____

Mother's Employer: ____________________________ Occupation: ______________________

Legal Guardian's Name (if different from mother & father): ______________________________

Home Phone# ___________________________ Work Phone# __________________________

Cell Phone# ___________________________ Other Phone# __________________________

Email Address: ____

Does child live with both biological parents? Y - N Are parents divorced or separated Y – N

If parents divorced, did you bring a copy of your divorce decree Y – N

Child's School: ____ Grade: ____

Was child referred to counseling? Y - N If Yes, by whom?__________________________

Names and ages of others living in your home:

Name: Age: Relationship:

____

____

____

____

____

Issues to be discussed / reasons for child being brought to counseling: ______________________

____

____

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

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

NHCC ASSESMENT and HISTORY INFORMATION

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

Patient's Name: ____ Date: _______________

☐ YES ☐ NO Has / Is child ever been treated by a psychiatrist? Who? ______________________

If yes, would you give consent to therapist to communicate with psychiatrist? Yes: ___ No: ___

☐ YES ☐ NO Has child ever been treated by a counselor? Who? ___________________________

Patient's Physician: ____

Would you give consent to therapist to communicate with PCP? Yes: ____ No: ____

Last time seen by physician: ____

Reason for visit: ____

Is patient on medication? Y ~ N If yes, what medication(s)_____________________________

____

____

☐ YES ☐ NO Has child been diagnosed with developmental problems?

☐ YES ☐ NO Any speech impairment problems?

☐ YES ☐ NO Has child been exposed to trauma?

☐ YES ☐ NO Any mental health problems on fathers/mothers family?

If yes, please indicate who and what diagnosis?____

____

☐ YES ☐ NO Any complications during pregnancy?

☐ YES ☐ NO Any complications at birth?

Briefly describe your reasons for seeking counseling services: ____________________________

____

____

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

____

____

NHCC ASSESMENT and HISTORY INFORMATION Cont.

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
____Anger, hostility, irritable
____Anxiety, nervousness
____Attention, distraction
____Confusion
____Compulsions
____Cruelty to animals
____Crying, sadness
____Decision-making
____Delusions (false ideas)
____Depression
____Divorce, separation
____Eating problems
____Grieving
____Guilt
____Headaches
____Impulsiveness
____Judgment
____Loss of control
____Memory problems
____Mood swings
____Obsession/compulsion
____Panic/Anxiety attacks
____School problems
____Self-esteem
____Sleep problems
____Stress
____Substance Abuse
____Suicidal thoughts
____Temper/low tolerance
____Thought disorganization
____Bed wetting
____Other ______________

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

☐ YES ☐ NO If yes, who?:____ When: ____________

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

☐ YES ☐ NO If yes, who?:____ When: ____________

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

_____ Child / teen is close and has a good relationship with siblings.

_____ Child / teen has several friends

_____ Child / teen often has nightmares.

_____ Child / teen prefers to spend time alone.

_____ Child / teen does not make eye contact when spoken to.

_____ Child / teen does not like being around other people.

_____ Child / teen likes self.

_____ Child / teen enjoys outdoor activities

_____ Child / teen enjoys school

_____ Child / teen spends at least 3 hours per day on electronics

_____ Child / teen is responsible for chores / responsibilities

CONFIRMATION OF RIGHT TO CONSENT TO SERVICES

I, ___________________________________ hereby confirm and verify that I hold and maintain the right to consent to the provision of psychological counseling for the following child:
Child's name: ____________________________ Date of Birth: ____/____/_____

CONSENT TO SERVICES

This is to certify that I, ____________________________________ give permission for the above-named child to receive counseling from New Horizon Counseling Center.

______________________________ ______________________________

Parent / Guardian Signature Date Therapist Signature Date