Trinity Church Counseling

7002 Canton Ave
Lubbock, TX 79413
806-792-3363

INFORMED CONSENT AND RELEASE OF LIABILITY

Our goal is to provide you with quality counseling. Some clients need only a few sessions to achieve these goals while others may require many more. As a client, you have the right to end our counseling relationship at any point.

1. I understand that my counselor is working under Texas laws, rules and statutes as a Licensed Professional Counselor (LPC).

2. I understand that my counseling records are kept confidential, except where disclosure is required by law or the ethics of the counseling profession. I have received a copy of Trinity Church Counseling's ("TCC") **Notice of Privacy Practices** which explains in detail the full extent of confidentiality and privacy regarding my protected health information. Possible exceptions to confidentiality may include but are not limited to the following situations:

- abuse of a child, elderly or disabled person
- potential harm or threat to self or others
- third party requests for payment
- child custody cases that go before a court of law
- information subpoenaed by a court of law

3. In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable Nathan Futrell, M.A., LPC or Trinity Church, its employees or members from any and all claims, demands, actions, or causes of action of whatsoever kind and nature related to the counseling process.

4. The clinical records are the property of Nathan Futrell, M.A., LPC and are deemed records of confidential sessions between therapist and clients. I waive any right I may otherwise have to seek to use the clinical records as evidence in any judicial proceedings. I understand that if subpoenaed or court ordered to testify in court as an expert witness, court fees are separate from the counselor's regular counseling rates. Court appearances, depositions, and attorney consultations are $150.00 per hour (including all time involved in preparation, research, parking fees, mileage, travel time to and from the court house and all other expenses incurred in relation to testifying). A retainer of $900.00 is to be paid prior to the court date. If the full amount of the retainer is not needed to complete the court testifying process, then the remainder of the funds will be refunded. If the costs for the testifying process exceed the amount of the retainer then those fees will be billed to you and are due upon receipt of the invoice. The party issuing the subpoena is responsible for the testifying fees.

5. Counseling sessions last approximately forty-five to fifty (45-50) minutes. **24-hour notice is required for all cancellations to avoid a $40.00 fee.** Fees are due at the beginning of each session. *All accounts are required to have a credit card, non-dated check, or cash should a late cancellation/missed appointment occur on file to reserve future appointments.*

☐ check ☐ $40 cash ☐ Credit Card Number: ______________________________ Exp. Date:__________ CVV:________

Name on Card: ______________________________ Billing Address:______________________________________

Billing Zip Code: ____________________ Type of Card: ☐ DC ☐ VISA ☐ MC

6. If at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance. We do not provide an on-call service at this time. You can also contact the National Suicide Prevention Lifeline at 1-800-273-TALK

I, the undersigned, consent to Trinity Church Counseling Notice of Privacy Practices. My signature below indicates that I grant informed consent for Nathan Futrell, M.A., LPC to provide psychological services and counseling to myself and/or minor members of my family. I further understand that without 24-hour notice of cancellation, I will be charged $40.00.

Client/Guardian Printed Name: ______________________________________ Date: ____________

Client/Guardian Signature: ______________________________________ Date: ____________

Child/Adolescent Client Form

Today's Date: **Completed By:** ☐ Self ☐ Other (Name and Relationship):

Referred by:

CHILD/ADOLESCENT INFORMATION		
Name: ☐ M ☐ F	DOB:	Age:
Street Address:	Home Phone:	
City, State, Zip:	Cell Phone:	
Race: ☐ African-American ☐ Asian/Pacific Islander ☐ Caucasian/White ☐ Hispanic ☐ Native American ☐ Other:		

PARENT/GUARDIAN INFORMATION	
Mother Name:	Father Name:
Street Address (if different):	Street Address (if different):
City, State, Zip:	City, State, Zip:
Cell/Home Phone:	Cell/Home Phone:
Work Phone:	Work Phone:
Email:	Email:
Occupation:	Occupation:
Marital Status of Biological Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	

EMERGENCY CONTACT	
Name:	Relationship:
Home Phone:	Cell Phone:

PRESENTING CONCERNS
Please describe why your child/adolescent is coming to counseling:
What events led you here today? What specific symptoms/problems is your child/adolescent experiencing?
What do you hope your child/adolescent will gain or change by coming to counseling?

ACADEMIC HISTORY

What is your child/adolescent's current grade: Which, if any, grades did they repeat?

Child/Adolescent's School:

Has your child/adolescent ever been told they have special educational needs? ☐ Yes ☐ No **If yes,** what was done about it (testing, special evaluation, special classes, development of an IEP/504, alternative school, change of teacher).

Does your child/adolescent have problems in school with: ☐ Grades ☐ Behavior ☐ Detention ☐ Suspension ☐ Expulsion ☐ Bullying

EARLY PERSONAL HISTORY

What city and state was your child/adolescent born?

Who currently lives in the home with the child/adolescent?

How many **siblings** does your child/adolescent have? _______ = Brothers ________ Sisters _______ Half-Brothers_______ Half-Sisters _______

Where is your child/adolescent in the birth order (e.g., youngest, oldest)?

Who is raising your child/adolescent? ☐ Both parents ☐ Mom ☐ Dad ☐ Grandparents ☐ Foster home ☐ Other ___________

Describe your child/adolescent's early home life:

Has your child/adolescent ever been: ☐ Physically abused? ☐ Sexually abused? ☐ Emotionally abused?

Who abused them and how? How old were they when this happened?

MENTAL HEALTH & MEDICAL HISTORY

Has your child/adolescent ever seen a psychologist, psychiatrist, or counselor? ☐Yes ☐No

List all mental health or substance abuse diagnoses your child/adolescent has had: ☐ None

Has your child/adolescent ever been suicidal? Please explain.

Do any family members have mental health problems?

Has your child/adolescent ever had a head injury or been hit in the head? ☐Yes ☐No Did they lose consciousness? ☐Yes ☐No

List any medical problems.

Mental Health/Substance Abuse Hospitalizations (Inpatient, PHP, IOP - Use back page if necessary.)

Date	Reason for Treatment	Hospital	Duration of Treatment	Treatment Response (helpfulness)

Counseling/Therapy (Individual, Family, Group, Play Therapy - Use back page if necessary.)				
Date	Reason for Treatment	Treatment Provider	Duration of Treatment	Treatment Response (helpfulness)

Current Medications (List any prescription medications your child/adolescent is currently taking. Use back if necessary)					
Name of Drug	Reason for Taking It	Date Started	Frequency Taken	Strength	Has it been helpful?
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
Describe any side effects that they find troublesome from any of the medications they are currently taking.					
Does your child/adolescent generally take their medications as prescribed? ☐ Yes ☐ Take too much ☐ Don't always take					
What other psychiatric medications have they taken in the past?					

Substance Use (List all of the substances that your child/adolescent has used or tried)			
Substance	Age 1st Began	Highest Use	Date of Last Use
☐ Alcohol		☐ Daily ☐ Few times/Week ☐ weekends ☐ Occasionally	
☐ Marijuana		☐ Daily ☐ Few times/Week ☐ weekends ☐ Occasionally	
☐ Cocaine/Crack / Meth / Speed		☐ Daily ☐ Few times/Week ☐ weekends ☐ Occasionally	
☐ Heroin/Opiates		☐ Daily ☐ Few times/Week ☐ weekends ☐ Occasionally	
☐ Inhalants (gas, antifreeze)		☐ Daily ☐ Few times/Week ☐ weekends ☐ Occasionally	
☐ Hallucinogens		☐ Daily ☐ Few times/Week ☐ weekends ☐ Occasionally	
☐ Prescription **abuse**		☐ Daily ☐ Few times/Week ☐ weekends ☐ Occasionally	
☐ Other		☐ Daily ☐ Few times/Week ☐ weekends ☐ Occasionally	

ACTIVITIES OF DAILY LIVING / SOCIAL FUNCTIONING

(Use the back of pages as necessary to answer completely)

What time does your child/adolescent: get up in the morning? go to bed at night?

What does your child/adolescent do with their time? How do they spend their day?

List your child/adolescent's **close** friends and how long they have known them:

RELIGIOUS HISTORY

Is your child/adolescent religious/spiritual?

What role does religion/spirituality play in your child/adolescent's life?

How regularly does your child/adolescent attend religious/spiritual services?

LEGAL HISTORY

How many **juvenile arrests** has your child/adolescent had? When and what were they for?

How many times has your child/adolescent been: in jail? ______ convicted? ______ on probation? ______ violated probation? _______

CURRENT STATUS

Please check any of the following that apply to your child/adolescent presently or in the recent past:

Abuse, Physical	Drug Use	Nervousness	Tension
Abuse, Sexual	Eating Problems	Loss of Control	Terminal Illness
Abuse, Verbal	Emotional Abuse	Loss of energy	Trauma
Aggressive	Friends	Making Decisions	Trouble Relaxing
Alcohol Use	Grief	Pain	Unhappiness
Anger	Guilt	Panic	Unwanted Thoughts
Anxiety	Headaches	Problems sleeping	Other_______________
Bad Dreams	Hearing Noises	Rapid Heart Rate	
Change in Appetite	Hearing Voices	Racing Thoughts	
Communication	Hopelessness	Recent Loss	
Compulsivity	Impulsive	Seeing Things	
Dizziness	Inferior Feelings	Self-Control	
Concentration	Legal Matters	Shyness	
Cutting/Self harm	Loneliness	Stress	
Difficulty Breathing	Memory	Stomach Trouble	