

Couples Intake Packet

Thank you for choosing Crossroads Family Counseling Center, LLC. In order to assist you in understanding the responsibilities and expectations in counseling, please read and sign the following intake packet. Appointment times range from 50 to 75 minutes depending on your needs. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

Partner 1

Date: _____

Name: _____

Address: _____

City _____ State: _____ Zip: _____

Phone: (Home) _____ (Cell) _____ (Work) _____

Email: _____

Do you prefer to be reminded of appointments by: Text Home Phone Cell E-mail

If Text, list Cell Phone provider: _____

Would you like to join Crossroads emailing list to receive updates on events and free information?

Yes ___ No ___

Date of Birth: _____ Sex: Male ___ Female ___

Level of education: HS ___ College ___ Graduate Degree ___ Other ___

Employer: _____ Occupation: _____

How long have you worked there? _____ How long in this occupation? _____

Name of Spouse/ Partner: _____

Date of Birth: _____ Relationship Status: _____

Years Married: Present marriage _____ Previous Marriage(s) _____

Emergency Contact Person: _____

Phone: _____ Relationship: _____

Children(s) Names

Age

Sex

Others living at home: _____

How did you hear about us: _____

May we thank them for the referral? Yes ___ No ___

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If on the internet please let us know how. (Check if applicable)

- | | |
|---|---|
| <input type="checkbox"/> Google | <input type="checkbox"/> Crossroads Website |
| <input type="checkbox"/> Psychology Today | <input type="checkbox"/> Bing |
| <input type="checkbox"/> Good Therapy | <input type="checkbox"/> Facebook/Twitter |
| <input type="checkbox"/> Theravive | <input type="checkbox"/> Other |

If referred by a doctor, may we have permission to contact that doctor? Yes ___ No ___

Name: _____

Address: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Date of last physical examination: ___/___/___

If you are taking any medications, please list:

| Medication(s)-Prescription and Over the Counter | Dosage | Prescribed For |
|---|--------|----------------|
| | | |
| | | |
| | | |

How would you describe your overall health: Excellent ___ Good ___ Fair ___ Poor ___

Previous Hospitalizations:

List any significant health problems: _____

Have you ever been inpatient for mental health reasons? Yes ___ No ___ Date(s) ___/___/___

Are you currently suicidal? Yes ___ No ___ Suicidal thoughts only? Yes ___ No ___ Previous suicide attempts? Yes ___ No ___ Date(s) ___/___/___, ___/___/___, ___/___/___

Any aggressive/ violent thoughts or acts? Yes ___ No ___

Any past aggressive/violent thoughts or acts? Yes ___ No ___

Substances Used/ Abused:

| Current | Past | Current | Past | Current | Past |
|---------|------|---------|------|---------|------|
| ___ | ___ | ___ | ___ | ___ | ___ |
| ___ | ___ | ___ | ___ | ___ | ___ |
| ___ | ___ | ___ | ___ | ___ | ___ |

Do you smoke Yes ___ No ___ If yes, how much/day? _____

Current Concerns:

Briefly describe the marital/relational problem that is bringing you into therapy.

When did these problems begin?

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On a scale of 1-10, rate you relationship's current level of distress: (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

In what ways have you and your partner attempted to cope/solve with this problem?

Have you tried couple's therapy/counseling before? YES _____ NO _____

If yes, when and with whom? _____

Give a brief description of treatment: _____

Please complete the individual symptoms checklist below. Check all that apply:

| Current | Past | | Current | Past | |
|---------|------|----------------------------------|---------|------|---|
| ___ | ___ | Depressed Mood | ___ | ___ | Recurrent and Persistent thoughts/behaviors |
| ___ | ___ | Daily Irritability | ___ | ___ | Difficulty controlling anger/bad temper |
| ___ | ___ | Physical abuse | ___ | ___ | No interest/pleasure in activities |
| ___ | ___ | Sexual abuse | ___ | ___ | Difficulty sleeping/ poor sleep |
| ___ | ___ | Increase/decrease need for sleep | ___ | ___ | Distressing memories that reoccur |
| ___ | ___ | Difficulty concentrating | ___ | ___ | Recurrent distressing dreams |
| ___ | ___ | Difficulty making decisions | ___ | ___ | Delusions (unreasonable thoughts/beliefs) |
| ___ | ___ | Fatigue or loss of energy | ___ | ___ | Do you hear or see things others do not? |
| ___ | ___ | Feelings of worthlessness | ___ | ___ | Not able to control the impulse to steal |
| ___ | ___ | Feelings of hopelessness | ___ | ___ | Preoccupation with or frequent gambling |
| ___ | ___ | Recurrent thoughts of death | ___ | ___ | Sense of reliving traumatic events |
| ___ | ___ | Racing thoughts or ideas | ___ | ___ | Periods of time you can't remember |
| ___ | ___ | Rapid mood swings | ___ | ___ | Intense reactions to certain events/anniversaries |
| ___ | ___ | Shortness of breath/dizziness | ___ | ___ | Avoidance of thoughts or feelings of trauma |
| ___ | ___ | Sweating/feeling flushed | ___ | ___ | Avoidance of activities or situation of trauma |
| ___ | ___ | Choking | ___ | ___ | Detachment from feelings, people, places |
| ___ | ___ | Nausea or abdominal distress | ___ | ___ | Binging/ compulsive overeating |
| ___ | ___ | Feeling unreal | ___ | ___ | Intentional vomiting |
| ___ | ___ | Numbness or tingling | ___ | ___ | Laxative or diuretic use |
| ___ | ___ | Fear of dying | ___ | ___ | Excessive dieting |
| ___ | ___ | Sexual orientation issues | ___ | ___ | Compulsive sexual behaviors |
| ___ | ___ | Fear of going crazy | ___ | ___ | Accelerated heart rate/chest pains |

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Revised Dyadic Adjustment Scale

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

| | Always Agree | Almost Always Agree | Occasionally Agree | Frequently Disagree | Almost Always Disagree | Always Disagree |
|---|--------------|---------------------|--------------------|---------------------|------------------------|-----------------|
| 1. Religious Matters | | | | | | |
| 2. Demonstrations of affection | | | | | | |
| 3. Making major decisions | | | | | | |
| 4. Sex Relations | | | | | | |
| 5. Conventionality (correct or proper behavior) | | | | | | |
| 6. Career decisions | | | | | | |

| | All the time | Most of the time | More often than not | Occasionally | Rarely | Never |
|---|--------------|------------------|---------------------|--------------|--------|-------|
| 7. How often do you discuss or have you considered divorce, separation, or terminating your relationship? | | | | | | |
| 8. How often do you and your partner quarrel? | | | | | | |
| 9. Do you ever regret that you married (or lived together)? | | | | | | |
| 10. How often do you and your mate "get on each other's nerves"? | | | | | | |

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| | Every Day | Almost Every Day | Occasionally | Rarely | Never |
|--|-----------|------------------|--------------|--------|-------|
| 11. Do you and your mate engage in outside interests together? | | | | | |

How often would you say the following events occur between you and your mate?

| | Never | Less than once a month | Once or twice a month | Once or twice a week | Once a day | More often |
|--|-------|------------------------|-----------------------|----------------------|------------|------------|
| 12. Have a stimulating exchange of ideas | | | | | | |
| 13. Work together on a project | | | | | | |
| 14. Calmly discuss something | | | | | | |

Please answer the following questions:

To whom did you go to for comfort when you were young? _____

Could you count on this person/these people for comfort? _____

When were you most likely to be comforted by this person/these people? _____

How did you let this person/these people know that you needed connection/comfort? _____

Did this person ever betray you? _____ Were they unavailable at critical times? _____

What did you learn about comfort and connection from this person/people? _____

If no one was safe, how did you comfort yourself? How did you learn that people were unsafe? _____

Did you ever turn to alcohol, drugs, sex or other things for comfort? _____

Have there been times when you have been able to be vulnerable and find comfort with your partner? _____

Have there been any particular traumatic incidences in your previous romantic relationships? _____

How have you tried to find comfort in romantic relationships? _____

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Partner 2

Date: _____

Name: _____

Address: _____

City _____ State: _____ Zip: _____

Phone: (Home) _____ (Cell) _____ (Work) _____

Email: _____

Do you prefer to be reminded of appointments by: Text Home Phone Cell E-mail

If Text, list Cell Phone provider: _____

Would you like to join Crossroads emailing list to receive updates on events and free information?

Yes ___ No ___

Date of Birth: _____ Sex: Male ___ Female ___

Level of education: HS ___ College ___ Graduate Degree ___ Other ___

Employer: _____ Occupation: _____

How long have you worked there? _____ How long in this occupation? _____

Name of Spouse/ Partner: _____

Date of Birth: _____ Relationship Status: _____

Years Married: Present marriage _____ Previous Marriage(s) _____

Emergency Contact Person: _____

Phone: _____ Relationship: _____

| <u>Children(s) Names</u> | <u>Age</u> | <u>Sex</u> |
|--------------------------|------------|------------|
| _____ | | |
| _____ | | |
| _____ | | |

Others living at home: _____

How did you hear about us: _____

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May we thank them for the referral? Yes ___ No ___

If on the internet please let us know how. (Check if applicable)

- | | |
|---|---|
| <input type="checkbox"/> Google | <input type="checkbox"/> Crossroads Website |
| <input type="checkbox"/> Psychology Today | <input type="checkbox"/> Bing |
| <input type="checkbox"/> Good Therapy | <input type="checkbox"/> Facebook/Twitter |
| <input type="checkbox"/> Theravive | <input type="checkbox"/> Other |

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Name: _____

Address: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Date of last physical examination: ___/___/___

If you are taking any medications, please list:

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List any significant health problems: _____

Have you ever been inpatient for mental health reasons? Yes ___ No ___ Date(s) ___/___/___

Are you currently suicidal? Yes ___ No ___ Suicidal thoughts only? Yes ___ No ___ Previous suicide attempts? Yes ___ No ___ Date(s) ___/___/___, ___/___/___, ___/___/___

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| Current | Past | Current | Past | Current | Past |
|---------|------|---------|------|---------|------|
| ___ | ___ | ___ | ___ | ___ | ___ |
| ___ | ___ | ___ | ___ | ___ | ___ |
| ___ | ___ | ___ | ___ | ___ | ___ |

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|--|-----------|------------------|---------------|--------|-------|
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Did this person ever betray you? _____ Were they unavailable at critical times? _____ What did you learn about comfort and connection from this person/people? _____

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Have there been times when you have been able to be vulnerable and find comfort with your partner? _____

Have there been any particular traumatic incidences in your previous romantic relationships? _____

How have you tried to find comfort in romantic relationships? _____

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Instructions: Please review together and sign.

INFORMED CONSENT:

Education and Services: Travis E. Frye MA, LPC has earned a Master's Degree in Marriage and Family Therapy. He is licensed in AZ as a Licensed Professional Counselor. Travis E. Frye MA, LPC is trained in and practices Emotionally Focused Therapy, or EFT. EFT is a short term (8-20 sessions) structured approach to couples therapy formulated by Dr. Susan Johnson and Les Greenberg in the early 80's. The strategies and techniques of EFT are also used with families. A substantial body of research outlining the effectiveness of EFT now exists. This research demonstrates that couples significantly improve over the course of treatment and continue to get better at two year follow up. Please refer to the EFT website for further information about the treatment model and present outcome research: www.eft.ca. The goals of EFT are:

1. To expand and re-organize key emotional responses.
2. To create a shift in partner's interactional patterns.
3. To foster the creation of a SECURE bond between couples and families.

In addition to being a Certified EFT Therapist, Travis E. Frye MA, LPC is an EFT Supervisor-in-Training and certified as an anger management and grief and loss therapist. Treatment approaches are used depending on the person and/or condition. Treatment practices, philosophy, and risks will be discussed with you today.

Signature(s) _____ Date: _____
Signature(s) _____ Date: _____

Purpose and Limitations of Therapy: Counseling has been shown to have many benefits, including better relationships, solutions to specific issues, and significant reduction in feelings of distress. However, there are no guarantees of what you will experience. The process of therapy involves working through tough personal issues that may result in uncomfortable emotions such as anger, fear, or frustration. Attempting to resolve these issues may result in changes that were not originally intended. Therapy may result in decisions about changing behaviors, employment, substance use, education, relationships, or any other area of your life.

At times, a decision deemed as personal growth for one family member, may be viewed negatively by another family member. Change can be easy, but usually it is slow and frustrating. In family counseling, interpersonal conflict may increase as we discuss family problems and issues. You have the right to refuse any recommended treatment or to withdraw consent to therapy and to be advised of the possible consequences of withdrawal or refusal. I welcome your input and questions about our course of treatment. *Your satisfaction in therapy is very important to me!*

Our relationship is very unique and it is exclusively a therapeutic, professional relationship. Thus, it is inappropriate for a client and therapist to have a social relationship. Bestowing gifts and

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attending family or religious functions would be a violation of the boundaries of our therapeutic relationship that serves to protect your confidentiality.

If you ever feel you have been treated unfairly or disrespectfully, please talk with me about it. This is never my intention, but at times misunderstandings can result in hurt feelings. Addressing these issues right away is important so that your progress in therapy is not hindered.

Signature(s) _____ Date: _____
Signature(s) _____ Date: _____

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

All information regarding your counseling is confidential and will not be released to any other person or agency without your written permission. At times therapy will involve the participation of more than one family member and/or significant persons. While Travis E. Frye MA, LPC will attempt to follow your wishes; he does not guarantee confidentiality among participants in therapy. There are certain situations in which Travis E. Frye MA, LPC is required by law to reveal information obtained during therapy to other persons or agencies without your permission. These situations include:

1. If you threaten bodily harm or death to another person, Travis E. Frye MA, LPC is required by law to inform the intended victim and appropriate law enforcement agencies.
2. If you threaten bodily harm or death to yourself, Travis E. Frye MA, LPC will inform the appropriate law enforcement agencies and others (such as spouse, friend, or inpatient psychiatric institution) who could aid in prohibiting you from carrying out your threats.
3. If you reveal information related to the abuse or neglect of a child, dependent adult, or elderly person, Travis E. Frye MA, LPC is required by law to report this to the appropriate authorities.

Travis E. Frye MA, LPC is available by phone for minor emergencies Monday through Friday from 8am to 8pm. If an urgent emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community, 602-222-9444 or 911, for those services. Travis E. Frye MA, LPC will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s) _____ Date: _____
Signature(s) _____ Date: _____

Limitation on Confidentiality when Providing Therapy to Couples or Families: This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are

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involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the _____ (couple/family or other unit) being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with your Travis Frye MA, LPC and that we enter couple/family therapy in agreement with this policy.

Signature(s) _____ Date: _____
Signature(s) _____ Date: _____

YOUR RIGHTS AS A CLIENT:

1. As a client with Crossroads Family Counseling, you have the right to feel safe and comfortable with your counselor. If at any time you feel unsafe, bring this concern to my attention. I believe your relationship with me is a primary determinant for your successful outcomes in treatment.
2. You have the right to ask questions about any procedures during therapy.
3. You have the right at any time not to receive therapy through Crossroads Family Counseling Center, LLC and Travis Frye MA, LPC. If you wish, he will provide you with the names and contact information for other qualified professionals whose services you might prefer.
4. You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued.

Signature(s) _____ Date: _____
Signature(s) _____ Date: _____

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FEE SCHEDULE:

Payment is due at the time of service. The fee for services is as follows:

50- minute session - \$130.00 75- minute session - \$180.00

VIP session (3hrs) - \$429.00

If you have out-of-network benefits, your insurance may reimburse you for a portion of this fee. If you do have this type of coverage, you must still pay at the time of service and you will be responsible for pursuing any reimbursement from your insurance company. Upon request we will provide you with a receipt for services for you to submit to your insurance. You may pay with cash, credit or debit card (Visa, Master Card, & Discover). **At your first appointment you will be required to give your credit card information and agree to authorize Crossroads Family Counseling Center, LLC to charge that card for your sessions in the event that other payment has not been made at the time of service, or in the event of late cancellation or missed session that was not cancelled prior to 24 hr notice.**

Phone Contact is billed at the same rate as face-to-face sessions. There is no charge for phone calls lasting 10 minutes or less.

Cancellations and Missed Appointments:

Please be aware that you may leave a message to cancel your appointment 24hrs a day. As long as you cancel your appointment at least 24-hours in advance from the time your appointment was scheduled, you will not be charged. However, **you will be billed the full session fee for any cancellations made in less than 24 hours prior to your scheduled appointment.** Please be aware that insurance generally does not reimburse clients for missed or late-cancelled appointments.

Unpaid Balances:

Please be aware that Crossroads Family Counseling Center, LLC **will be unable to continue seeing you for scheduled sessions once you accrue an overdue balance of \$260 or more, or if you no-show three consecutive sessions.** Your file will be closed and a letter notifying you of this will be sent to the address listed on your intake paperwork.

I authorize the following credit card to be on file and for Crossroads Family Counseling Center, LLC to charge this credit card under the following circumstances: 1) **services received for which other payment has not already been made**, 2) **appointments that I miss or cancel within less than 24 hours of my scheduled time**, and 3) **phone consultations lasting longer than 10 minutes.**

Credit Card Type: _____ Visa _____ MasterCard _____ Discover _____

Name as it appears on the card: _____

Credit Card Number: _____ / _____ / _____ / _____

Expiration Date: ____ / ____

CVC Code (3-digit code on back of card): _____

Client's Printed Name: _____

Client's Signature: _____ Date: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date: April 14, 2003

Crossroads Family Counseling Center, LLC has been and will always be totally committed to maintaining client's confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information maybe used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Arizona State Law, we are obligated to report this to the Department of Children and Family Services. If you provide information that informs us that you are in danger of harming yourself or others. Information to remind you of /or to reschedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

THIS IS FOR YOUR RECORDS. PLEASE SIGN THE INFORMED CONSENT STATING YOU HAVE REVIEWED THE INFORMATION ON THIS PAGE. THANK YOU!

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HIPAA NOTICE OF PRIVACY PRACTICES:

I have read and received a copy of the Notice of Privacy Practices.

Signature(s) _____ Date: _____

STATEMENT OF UNDERSTANDING:

I have read and understand the information contained within this packet and I give my informed consent to treatment.

Signature(s) _____ Date: _____
Signature(s) _____ Date: _____

Note: Please ask questions about things you don't agree with or understand. I welcome your feedback and opinion regarding your counseling experience. Thank you!