Crossroads Family Counseling
Phoenix and Scottsdale Relationship Centers

Client Intake Packet

Thank you for choosing Crossroads Counseling 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**. Office Addresses: 14300 N. Northsight Blvd Suite 218 Scottsdale 85260. 34406 North 27th Drive Suite 140, Building 6 Phoenix 85085.**

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)_____
Level of education: HS_____ College_____ Graduate Degree_____ Other_____
Employer:_____ Occupation:_____

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__

Client Intake Packet

If you found us on the internet please tell us how? (Check if applicable)

___Google ___Crossroads Website
___Psychology Today ___Bing
___Good Therapy ___Facebook/Twitter
___Theravive ___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
___	___ Alcohol	___	___ Prescription (RX)	___	___ Ecstasy
___	___ Cocaine	___	___ OTC Medication	___	___ Opiates
___	___ Marijuana	___	___ Narcotics	___	___ Other_____

Do you smoke Yes___ No___ If yes, how much/day? _____

Current Concerns:

Briefly, what difficulties or problems have brought you to see help at this time?

_____
_____

When did these problems begin? _____

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

In what ways have you attempted to solve these problems?

_____
_____

Client Intake Packet

Have you seen a therapist/counselor before? YES_____NO_____

If yes, when and with whom?_____

Give a brief description of treatment:_____

_____

_____

_____

_____

Please 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 sensations	____	____	Laxative or diuretic use
____	____	Fear of dying	____	____	Excessive dieting
____	____	Sexual orientation issues	____	____	Compulsive sexual behaviors
____	____	Fear of going crazy	____	____	Accelerated heart rate/chest pains

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?

_____

_____

Client Intake Packet

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?
_____
_____

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:_____

Client Intake Packet

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 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: _____

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 our 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: _____

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: _____

Client Intake Packet

FEE SCHEDULE:
Payment is due at the time of service. The fee for services is as follows:
50- minute session - $170.00 75- minute session - $220.00

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: _____

Client Intake Packet

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 INFORMATIION. 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!

Client Intake Packet

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 this information and am giving my informed consent to treatment.

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!