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.

Instructions: Parent/Guardian of the child please complete the paperwork listed below.

Date:_____

Parent/Guardian Name**:**_____

Parent/Guardian Name:_____

Family Address:_____

City_____State:_____Zip:_____

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

Parents 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___

How did you hear about us: _____
May we thank them for the referral? Yes__ No__

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

___Google	___Crossroads Website
___Psychology Today	___Bing
___Good Therapy	___Facebook/Twitter
___Theravive	___Other

CHILD/ADOLESCENT PERSONAL HISTORY

Child's Name _____ Date of Birth _____ Age _____
Address _____
(leave blank if the same as parents)

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Emergency Contact Person: _____
Phone: _____ Relationship: _____

Family Members

Name	Age	Relationship

Parents' Marital History

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

Length of present marriage

_____

If divorced and/or separated who has custody?

_____

List any pertinent information (previous marriages, separations, history of marital problems,etc…)

_____
_____
_____
_____

Family History
List any family members who you may believe have any history of depression, drug or alcohol abuse, behavioral or learning problems etc.

Family Member	Condition

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List any family activities you regularly engage in (include organizations or churches you belong to)

_____
_____
_____

Medical/Developmental History

Pregnancy and Delivery (list any unusual circumstances or medical conditions) _____
_____
_____
_____

Were you concerned with any of your child's developmental milestones (walking, talking toilet training)?

_____
_____

Primary Care Physician:_____Phone:_____
Date of last physical examination: ___/___/___
If your child is taking any medications, please list:

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

How would you describe your child's overall health: Excellent ___Good___ Fair___ Poor___

Previous Hospitalizations:
List any significant health problems:_____
Has your child ever been inpatient for mental health reasons? Yes___ No ___Date(s) __/__/__
Is your child 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. Check if known or suspected.

Current	Past		Current	Past		Current	Past	
___	___	Alcohol	___	___	Prescription (RX)	___	___	Ecstasy
___	___	Cocaine	___	___	OTC Medication	___	___	Opiates
___	___	Marijuana	___	___	Narcotics	___	___	Other_____

Does your child smoke Yes___ No___ If yes, how much/day? _____

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Educational History

Current school _____ Grade _____ Teacher _____

List any past or present academic concerns _____
_____
_____

Peer relationships

Is your child more of a leader or a follower? _____
Does your child prefer to play with children who are the same age, older, or younger? _____
Does your child have any behaviors that cause loss of friends? _____
_____

Current Concerns

Briefly describe the problem that is bringing you into therapy.

_____
_____
_____

When did these problems begin?

_____
_____

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

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

_____
_____
_____

Have you tried family/child therapy/counseling before? YES_____NO_____

If yes, when and with whom?_____

Give a brief description of treatment:_____
_____
_____
_____

Physical or Sexual Abuse
Do you have any concerns that your child has been physically or sexually abused? _____
_____

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Instructions: Please check if applicable now or in the past.

- ☐ Often doesn't seem to listen _____
- ☐ Easily distracted _____
- ☐ Overactive _____
- ☐ Wets the bed _____
- ☐ Soils or wets pants during the day _____
- ☐ Frequently angry or irritable _____
- ☐ Frequently sad _____
- ☐ Cries often _____
- ☐ Frequently tired _____
- ☐ Eats too much or too little _____
- ☐ Sleeps too much or too little _____
- ☐ Mood swings _____
- ☐ Talks back, argues excessively _____
- ☐ Frequent physical complaints _____
- ☐ Excessive worry _____
- ☐ Talks about hurting self or others _____
- ☐ Has hurt self or others _____
- ☐ Sets fires _____
- ☐ Steals _____
- ☐ Runs away _____
- ☐ Afraid to be alone _____
- ☐ Nightmares _____
- ☐ Truancy_____
- ☐ Legal Issues_____
- ☐ Other_____

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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.

Parent/Guardian 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

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.

Parent/Guardian 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.

Parent/Guardian Signature(s)_____ /_____Date:_____

Consent for treatment of an child or adolescent under the age of 18: 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 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.

Parent/Guardian 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.

Parent/Guardian 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 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.

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