

**Crossroads Family Counseling**  
Phoenix and Scottsdale Relationship Centers  
**Client 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.

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: \_\_\_\_\_

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

Others living at home: \_\_\_\_\_

How did you hear about us: \_\_\_\_\_

May we thank them for the referral? Yes \_\_\_ No \_\_\_

**Crossroads Family Counseling**  
 Phoenix and Scottsdale Relationship Centers  
**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
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___

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)

**Crossroads Family Counseling**  
 Phoenix and Scottsdale Relationship Centers  
**Client Intake Packet**

In what ways have you attempted to solve these problems?

---



---

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

**INFORMED CONSENT:**

**Education and Services:** Lauren Jack MC, LAC has earned a Master's degree in Counseling. She is licensed in AZ as a Licensed Associate Counselor under the supervision of Travis E. Frye MA,LPC of Crossroads Family Counseling Center, LLC. At all times clients are considered clients of Crossroads Family Counseling Center, LLC. Lauren Jack MC, LAC is trained in and practices Eye Movement Desensitization Reprocessing, or EMDR. EMDR is a psychotherapy that enables people to heal from the symptoms and emotional distress that are the result of

disturbing life experiences. Repeated studies show the by using EMDR people can experience the benefits of psychotherapy that once took years to make a difference. Twenty positive controlled outcome studies have been done on EMDR. Some of the studies show that 84%-90% of single-trauma victims no longer have post-traumatic stress disorder or PTSD after only three 90-minute sessions. Another study, funded by the HMO Kaiser Permanente, found that 100% of the single-trauma victims and 77% of multiple trauma victims no longer were diagnosed with PTSD after only six 50-minute sessions. In another study, 77% of combat veterans were free of PTSD in 12 sessions. There has been so much research on EMDR that it is now recognized as an effective form of treatment for trauma and other disturbing experiences by organizations such as the American Psychiatric Association, the American Psychological Association and the Department of Defense. Given the worldwide recognition as an effective treatment of trauma, you can easily see how EMDR would be effective in treating the “everyday” memories that are the reason people have low self-esteem, feelings of powerlessness, and all the myriad problems that bring them in for therapy. Over 70,000 clinicians throughout the world use EMDR therapy. Millions of people have been treated successfully over the past 20 years. In addition to practicing EMDR Lauren Jack’s MA, LAC other modalities are Cognitive Behavioral Therapy (CBT) shown to effectively treat depression and anxiety, Mindfulness, A Healing Journey for Women, EFT, and ACT. 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: \_\_\_\_\_

**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.

**Crossroads Family Counseling**  
Phoenix and Scottsdale Relationship Centers  
**Client Intake Packet**

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 Crossroads Family Counseling Center, LLC and Lauren Jack MA, LAC will attempt to follow your wishes, she does not guarantee confidentiality among participants in therapy. There are certain situations in which Lauren Jack MA, LAC 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, Lauren Jack MA, LAC is required by law to inform the intended victim and appropriate law enforcement agencies.
2. If you threaten bodily harm or death to yourself, Lauren Jack MA, LAC 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, Lauren Jack MA, LAC is required by law to report this to the appropriate authorities.

Lauren Jack MA, LAC 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. Lauren Jack MA, LAC 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 Lauren Jack MA, LAC. If you wish, she 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: \_\_\_\_\_

**Crossroads Family Counseling**  
Phoenix and Scottsdale Relationship Centers  
**Client Intake Packet**

**FEE SCHEDULE:**

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

50- minute session - \$120.00      75- minute session - \$170.00

VIP session (3hrs) - \$396.00

**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: \_\_\_\_\_

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!**

**Crossroads Family Counseling**  
Phoenix and Scottsdale Relationship Centers  
**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!**