



Christian Counseling Associates
A Ministry of Cornerstone Lodge

Verone M. Travis, M.A., Licensed Professional Counselor Intern
Supervisor: J. David Dickerson, LPC-S, #9382

Christian Counseling Associates
405 Harwood, Bedford, Texas 76021-0405
972-639-5859
<http://www.grapevinecounseling.org>
veronetravis@grapevinecounseling.org

Information and Consent Statement

I am pleased that you have selected me as your counselor. This document is designed to inform you about my background, my approach to counseling and the nature of our professional relationship.

Qualifications and Supervision

With a Master's degree in Counseling from Dallas Baptist University, I have a general knowledge of theoretical approaches to human behavior and training in counseling techniques and will use those that are most appropriate for you. As a Licensed Professional Counselor Intern, I have passed the National Counselors Exam and hold a temporary license from the State of Texas. To earn my permanent license, I must accumulate experience with clients while under supervision of a Licensed Professional Counselor. I work under the direct supervision David Dickerson, LPC-S, who is also the executive director of Christian Counseling Associates. Please be aware that information about your case may be discussed with Mr. Dickerson as part of my supervision experience. (See "Confidentiality" below.)

Counseling Approach and Relationship

I use a multi-faceted approach to counseling which takes into account the spiritual, psychological, social and biological dimensions of the client. My approach to counseling is based on my Christian beliefs and worldview. I do not always use prayer or Scripture in session, but may do so if consistent with the values of the client, when it is requested or deemed appropriate. Clients should not feel any threat of having these values imposed on them in the counseling process.

The relationship which we establish and maintain will be characterized by mutual respect, responsibility and cooperation. It is important that we acknowledge that we have a professional relationship rather than a social one. Our contact will be limited to the sessions you arrange with me. You may learn some information about me personally as we work together during your counseling experience. However, it is important for you to remember that you are experiencing me largely in my professional role. I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, we will work together to achieve the best possible results for you.

Confidentiality

Everything that is communicated within our session is confidential information and cannot and will not be communicated to any other person or organization without your express written consent. This confidentiality applies to any and all records of your identity, diagnosis, session or progress notes, evaluation, treatment or treatment plan, as well as any



information communicated by phone, fax, or email.

Confidentially will not be maintained in the following situations:

- 1) You direct me, by means of a signed and dated written consent form, to disclose specific information to a person or organization of your choice. (Note: if you enter therapy as a married couple, both signatures will be required in order to release confidential information).
- 2) I determine that you are a danger to yourself or others, in which case I am required to inform a medical or a law enforcement agency.
- 3) I become aware of abusive or neglectful behavior toward a minor.
- 4) I become aware of abusive, neglectful, or exploitive behavior toward the elderly or disabled persons.
- 5) I am ordered by a court to disclose information.

Risks and Benefits

While the benefits of counseling can be tremendous, there are risks. Counseling can open up levels of awareness which could cause pain and anxiety. Clients may experience changes that could produce disruptions and turmoil in their lives as they seek to make changes. Personal change often means change in relationships. The client should be aware that those to whom they closely relate sometimes do not respond positively to their changes, and it may become necessary to deal with these relationship adjustments. However, therapy marks a season of growth, progress, and healing in a person's life. It must be left to the client to decide if the gain is worth the potential pain.

Referral Policy

The process of helping you address specific areas of your life is unique in that it inevitably is the catalyst for one or several personal issues to arise that may at first cause a certain amount of personal discomfort. The fact that this happens is a normal and natural part of the relational process occurring between us. It is my privilege, as the person chosen by you to be involved in the process, to help you work through the specific areas of discomfort. To this end, I anticipate and desire a good and productive professional relationship with you.

In the event that a particular dissatisfaction with my services should arise, I will be very willing to discuss the nature of your dissatisfaction and make a concerted attempt to move toward a reasonable solution acceptable to both of us. If for some reason we are unable to arrive at an acceptable solution, I will be willing to provide you with several referral sources.

If it happens that within the course of therapy, an issue arises that lies outside the realm of my professional competency, I will discuss this with you and provide you with several referral sources.

Fee Agreement and Cancellation Policy

My standard fee for a single 50-minute counseling session is \$90. To assist those who may have difficulty paying the standard fee, **we offer a sliding fee scale based on family income.** I will be happy to discuss this option with you prior to or during the first session.



Christian Counseling Associates
A Ministry of Cornerstone Lodge

Insurance companies do not reimburse for counseling provided by Interns. You will be responsible for paying the entire fee at the time of each counseling session. Fees may be paid by cash, by check made out to Christian Counseling Associates or by credit card. As your therapist, it will be my responsibility to keep track of the time and notify you during the session of when our time is nearing the end, and if possible within my schedule, give you the option of extending the session. If you decided to extend the session beyond the scheduled time, you will be charged additional fees for that time. An administrative fee of \$25 will be charged for checks returned due to insufficient funds.

In the event that a phone consultation is needed, an additional fee may be assessed for phone consultations in excess of 15 minutes.

If you will not be able to keep an appointment, please notify me 24 hours in advance. A notification of cancellation less than 24 hours in advance will be charged half the amount of the session. If no notification is given and a session is missed entirely, the full fee for the session will be charged.

Complaints may be filed in writing to the Texas State Board of Examiners, 100 West 49th Street, Austin, Texas 78756, 1-800-942-5540.

Please cut or tear this at the dotted line below, sign it and return it to me at our first meeting. You may keep the rest of the information for your records.

CLIENT OR PARENT SIGNATURES FOR INFORMED CONSENT

I have read and fully understand all of the disclosure statement provided to me by Verone M. Travis, MA, LPC Intern, and agree to the terms therein.

CLIENT SIGNATURE:

_____ DATE: _____

CLIENT SIGNATURE:

_____ DATE: _____

COUNSELOR SIGNATURE: _____

DATE _____



Christian Counseling Associates
A Ministry of Cornerstone Lodge

CLIENT INFORMATION

Primary Client _____
Last Name First Name MI Nickname

Address _____
Street City State Zip

Date of Birth _____ Age _____ Gender _____

Occupation _____ Grade Level _____

Education Level: ___ GED ___ High School Diploma ___ College Degree ___ Graduate Degree
Degree In _____

Person filling out form and relationship to client _____

Contact information for client or parent/guardian if client is a minor:

Home Phone _____ Work _____ Cell _____
Email _____

May we call you at your home? ___ Yes ___ No

May we call you at your office? ___ Yes ___ No

May we call you on your cell? ___ Yes ___ No

May we leave a message at your home? ___ Office? ___ Cell? ___

May we communicate with you via email regarding appointments and other business? ___ Yes ___ No

Current Marital Status of client:

___ Never Married ___ Married ___ Engaged ___ Divorced ___ Separated ___ Widowed

Name of Spouse (if applicable) _____ OR

Name of Parents (if client is a minor) _____

Names of other family/household members:

_____	Age _____	Gender _____	Relationship _____
_____	Age _____	Gender _____	Relationship _____
_____	Age _____	Gender _____	Relationship _____
_____	Age _____	Gender _____	Relationship _____
_____	Age _____	Gender _____	Relationship _____

Client's Previous Marital History (if applicable). If minor client has never married, please provide parent's previous marital history:

SELF:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____

SPOUSE:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____

For office use:

Therapist: _____

Diagnostic code: _____

Date of first session: _____ fee _____

CLIENT'S PERSONAL INFORMATION

For marital counseling clients, please have each partner fill out separate forms for the rest of the information. If minor is primary client, he/she should fill out the rest of the document.

Are you currently attending a church? ___ Yes ___ No

If yes, what is the name of the church? _____

What is the denomination of the church? _____

Do you have a personal relationship with Christ? ___ Yes ___ No ___ Unsure

Are religious or spiritual issues important in your life? ___ Yes ___ No

Are you aware of any religious or spiritual resources in your life that could be used to help you overcome your problems? ___ Yes ___ No

If yes, what are they? _____

Would you like prayer as part of your counseling? ___ Yes ___ No

Who referred you to our center? _____

How would you rate your health? _____

How many hours do you sleep each night? _____

Do you experience food cravings? ___ Yes ___ No

If so, for what items? _____

How would you rate your diet?

___ Very Healthy ___ Healthy ___ Average ___ Needs Improvement ___ Poor

Do you have addictive/abusive issues with: ___ Alcohol ___ Illegal Drugs ___ Prescriptions

___ Sex ___ Pornography ___ Gambling ___ Other: _____

Has your appetite or weight changed lately? _____

Are you currently on medication? ___ Yes ___ No

If so, please complete the following:

Medication	Dosage	Physician	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CLIENT'S PERSONAL CONCERNS

Briefly explain why you are coming to counseling and what you hope to gain from your experience.

How much are you troubled by this?

___ Constantly ___ Often ___ Somewhat ___ Not Very Much

Comments concerning this problem: _____

Have you been in counseling before? ___ Yes ___ No

If so, for each incidence you remember, please complete the following:

1. Who was the counselor? _____

What was the problem? _____

How many sessions over what period of time? _____

What were the results? _____

2. Who was the counselor? _____

What was the problem? _____

How many sessions over what period of time? _____

What were the results? _____

CLIENT'S THOUGHTS AND BEHAVIORS

Please check how often the following thoughts occur to you:

- 1. Life is hopeless. Never Rarely Sometimes Frequently
- 2. I am lonely. Never Rarely Sometimes Frequently
- 3. No one cares about me. Never Rarely Sometimes Frequently
- 4. I am a failure. Never Rarely Sometimes Frequently
- 5. Most people don't like me. Never Rarely Sometimes Frequently
- 6. I want to die. Never Rarely Sometimes Frequently
- 7. I want to hurt someone. Never Rarely Sometimes Frequently
- 8. I am so stupid. Never Rarely Sometimes Frequently
- 9. I am going crazy. Never Rarely Sometimes Frequently
- 10. I can't concentrate. Never Rarely Sometimes Frequently
- 11. I am so depressed. Never Rarely Sometimes Frequently
- 12. God is disappointed in me. Never Rarely Sometimes Frequently
- 13. I can't be forgiven. Never Rarely Sometimes Frequently
- 14. Why am I so different? Never Rarely Sometimes Frequently
- 15. I can't do anything right. Never Rarely Sometimes Frequently
- 16. People hear my thoughts. Never Rarely Sometimes Frequently
- 17. I have no emotions. Never Rarely Sometimes Frequently
- 18. Someone is watching me. Never Rarely Sometimes Frequently
- 19. I hear voices in my head. Never Rarely Sometimes Frequently
- 20. I am out of control. Never Rarely Sometimes Frequently

Please rate the following symptoms on a scale of 0-2:

0 = Not significant/Non-existent 1 = Moderate/Sometimes 2 = Frequent/Severe

- | | | | |
|------------------------------------|--------------------------|--|--------------------------|
| Excessive anger, easily frustrated | <input type="checkbox"/> | Hyperactivity | <input type="checkbox"/> |
| Mood swings (depression-manic) | <input type="checkbox"/> | Change or loss of friends | <input type="checkbox"/> |
| Excessive guilt or shame | <input type="checkbox"/> | Sexual problems | <input type="checkbox"/> |
| Loss of energy | <input type="checkbox"/> | Self-mutilation, cutting | <input type="checkbox"/> |
| Loss of interest in activities | <input type="checkbox"/> | Excessive stress | <input type="checkbox"/> |
| Suicidal thoughts | <input type="checkbox"/> | Anxiety or excessive fears | <input type="checkbox"/> |
| Suicide attempts (how many) | <input type="checkbox"/> | Learning disabilities | <input type="checkbox"/> |
| Lying | <input type="checkbox"/> | Work or school related problems | <input type="checkbox"/> |
| Manipulation | <input type="checkbox"/> | Hallucinations, delusions, thought distortions | <input type="checkbox"/> |
| Poor impulse control | <input type="checkbox"/> | Obsessive thoughts &/or compulsive behaviors | <input type="checkbox"/> |

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts/behaviors that occur frequently or are a concern to you.

EMERGENCY CONTACT

Whom should we contact in case of emergency?

Name

Address

Home Phone Cell Phone