

NAME: _____ TODAY'S DATE: _____

HOME ADDRESS: _____

CITY: _____ ZIP CODE: _____

MAILING ADDRESS (If different): _____

CITY: _____ ZIP CODE: _____

OKAY TO RECEIVE MAIL AT THIS ADDRESS? YES _____ NO _____

BIRTHDATE: _____ AGE: _____

GENDER: MALE _____ FEMALE _____

EMPLOYER: _____

SSN: _____ - _____ - _____ DRIVER'S LICENSE: _____ ST: _____

EMAIL ADDRESS: _____

CONTACT INFORMATION: Please indicate preferred number to use for contacting you:

SOURCE:	PREFERRED?	OK TO LEAVE MESSAGE/TEXT?
CELL PHONE: _____	_____	YES _____ NO _____
HOME PHONE: _____	_____	YES _____ NO _____
WORK PHONE: _____	_____	YES _____ NO _____

We will confirm or attempt to confirm appointments at least 24 hours in advance. You are ultimately responsible for keeping track of the appointments you make, and confirmation contact is a courtesy to help in that regard. Please see your Client Agreement for late cancellation and no-show policies.

PARTY RESPONSIBLE FOR PAYMENT (IF OTHER THAN THE CLIENT):

NAME: _____

RELATION SHIP TO CLIENT: _____

ADDRESS (IF DIFFERENT FROM CLIENT): _____

CITY: _____ ZIP CODE: _____

_____ I would like a quarterly statement of payments made mailed to me. Please only request a statement if truly needed for insurance or tax purposes. ***There will be a \$5.00 charge for statement preparation and mailing that will be assessed on the first visit of each quarter.***

As a reminder, we do not file insurance for payment. Charges are due at the time of your appointment. For your convenience, we accept cash, checks, VISA, MasterCard, American Express, and Discover cards. We will assist you with any information you need for your insurance company to file for reimbursement.

4:13 Center for Change

INDIVIDUAL and COUPLE/FAMILY COUNSELING PROCEDURES AND AGREEMENT

1. **APPOINTMENTS:** Counseling services to persons starting at age 12 are provided *by appointment only*. Appointments can be made by calling the 4:13 office. Individual (one person) counseling sessions are generally 50 minutes in length and are made according to the schedules of the counselor and client. Couple, marriage and/or family counseling sessions are 60 or 90 minutes in length as agreed upon in advance. Adults (persons over the age of 18) seeking appointments are required to make their own appointments due to confidentiality concerns (see below).

2. **MAXIMUM FEES:**

INDIVIDUAL Sessions: \$110.00 first session, \$90 thereafter

COUPLE/FAMILY Sessions: \$150.00 first session, \$135 thereafter

All fees are due at the time of each session unless other payment arrangements have been approved in advance. 4:13 Center for Change does not accept insurance assignment or reimbursement. Should you require a statement to file for reimbursement yourself, one will be provided at a nominal charge. We accept cash, checks, and credit/debit cards for payment.

3. **CANCELLATION POLICY:** 24-hour advance cancellation of an appointment is required, *including your initial intake appointment*. If emergencies arise that prevent this 24-hour minimum notice, please call as soon as possible to let the office know that you will not be able to keep an appointment. There are a limited number of appointments available each week, and your consideration in this area may clear the way for someone else to use the time that had been originally reserved for you. You may reschedule when you call to cancel or do so at another time. ***Appointments cancelled with less than a 24-hour notice will be charged a cancellation fee.*** Please see the provided explanation for these charges.

4. **NO-SHOW POLICY:** As above, when you do not keep your appointment, you may be preventing someone else from receiving needed counseling services. One no-show *may* be allowed; after the second incident, the office may choose to refuse reservation of future times and you may be given the names of outside, private professional counseling providers to access for future needs. ***You will also be charged for your session fee.***

5. **CONFIDENTIALITY:** All communications that occur between counselor and client are held in the strictest confidence. No information will be released without written release / authorization by the client or legal guardian. **However, under certain circumstances according to Texas statutes, confidentiality may be revoked:**

- § if the client is judged to be a danger to self or others
- § if child abuse is suspected/reported
- § if requested by parents of minor clients
- § if subpoenaed or court order *from a judge*

In these cases, the proper medical, social, or law enforcement agencies will be notified as well as appropriate family members or significant others and verification of such notification will be made in the client's file. Your counselor may also staff your case with other professionals in order to provide you with the best services possible; this is done without using your name or other particular identifying

information. All client records are maintained in locked cabinets with no access by persons other than 4:13 staff members. Clients with questions concerning policies, appointment times, or other matters are required to call for that information personally. NO information will be given to family members, spouses, etc., in order to protect the interests of each client without a signed release of information form, which is available from the 4:13 office.

6. **ELECTRONIC COMMUNICATIONS:** E-mails, fax transmissions, or other electronic communications sent to 4:13 staff members will be treated with the highest confidentiality standards; however, it is important to know it cannot be guaranteed that these communications will only be seen by the person to whom they are directed. If the information you wish to transmit is of a sensitive or confidential nature, it is advised that it be dropped off personally at the 4:13 offices or given to your counselor during one of your sessions to ensure an unbroken chain of communication.
7. **TELEPHONE/ELECTRONIC MEDIA COMMUNICATIONS:** Each client is asked for a preferred phone number for confirmation of appointments and other office needs. Please make certain that this number is private and that information may be left via text or on your voice mail should contact be needed. In the event that a counselor returns a client's communication requesting information and/or assistance, please know that these contacts will be documented in the client's file. **4:13 counselors reserve the right to limit services provided by telehealth, telephone, e-mail, or other form of communication other than face-to-face sessions. Excessive time requirements will be charged at session fee rates.**
8. **COMMUNICATIONS WITH OUTSIDE SOURCES / PROVIDERS:** 4:13 personnel may consent to communicate with persons as directed by individual clients at their request provided a signed release for that specific communication is in the client's file. These release forms will be provided at the client's request, and must be signed in the presence of the counselor. Fax transmissions of a release form will NOT be accepted. Your counselor may also request the privilege of communicating with an outside provider or source, and permission may be given by the client to do so through their signature on a release form. There may be a charge for the time spent in communication. Please discuss this with your counselor if the need arises.
9. **COURT APPEARANCES:** Please inform your counselor if you anticipate that your information may be needed for court proceedings. Your counselor may choose to offer community referrals in cases where it becomes apparent that court testimony by a counselor will be required. These cases may include (but are not limited to): child custody, divorce proceedings, criminal cases, et al. See the *4:13 Court Policies* for complete information concerning court appearances.
10. **CREDENTIALS:** Your 4:13 counselor has been found to be professionally competent to offer services through a number of credentialing sources. You may ask your counselor for these sources, or may request to see them. Licensed Professional Counselors are responsible for maintaining their credentials and staying in satisfactory compliance with the ethics and rules of each credentialing organization, including the Texas State Board of Examiners of Licensed Professional Counselors.
11. **GOALS OF COUNSELING:** In your initial session(s), your counselor will discuss the purposes and goals of counseling with you. You will also be informed of possible therapeutic techniques that may be utilized during your time in counseling. The counselor will inform you if any other professional will or may need to be consulted. Again, this will be done in the most confidential way possible.
12. **RISKS OF COUNSELING PARTICIPATION:** Please be advised that there are no guarantees of positive outcomes associated with the delivery of counseling or therapy services. Every effort will be made to ensure that each client has the best and least distressful experience while utilizing intervention services at 4:13. It is

important to consider that talk therapy and other forms of intervention may, in some cases, actually temporarily heighten distress for some individuals or carry other risks for participation. Should you feel this is the situation in your case, please discuss this with your counselor. Each client has the right to request referral or terminate services at any time during treatment.

13. **ALTERNATIVES TO COUNSELING:** It is important to consider that there are other avenues of possible improvement for certain conditions/situations other than engaging in the formal counseling process with a professional. These include, but are not limited to: speaking with a member of the clergy; speaking with your primary care physician or psychiatrist; talking with a good and trusted friend; attending an issue-specific support group; accessing issue information over the Internet or through telephone or telehealth help line services; the use of self-help media, such as books, CDs, DVDs, and videos; attending seminars, conferences and retreats that deal with topics of interest; and others. These are presented to provide you with full information concerning many of the possible choices of intervention you as a client may choose to pursue in place of or in addition to professional counseling services.
14. **EMERGENCIES:** In the event of what you may consider to be a counseling but not life-threatening emergency, you are asked to call the 4:13 offices during regular business hours to speak with your counselor or an available professional. Calls to the office will be returned as your counselor's schedule permits. After-hours, please call 9-1-1 if the situation is life-threatening, or call the after-hours/emergency line at **903-787-9112**. Cancelling or rescheduling an appointment is NOT considered an emergency. Please call during regular office hours for routine needs.
15. **HISTORY INFORMATION:** In the initial phases of counseling, your counselor may deem it necessary to take a complete background history including, but not limited to: family of origin, personal development, medical, spiritual, marital, sexual, and legal information. This information may be requested in order to determine the appropriate counseling modalities and to ensure the best possible care. Your permission to grant this inquiry is given by your signature on this agreement. You may want to consider constructing a written LIFELINE of important, impactful life events that may help in this effort prior to your initial intake session. You will also be asked to fill out a form concerning current medications, both as prescribed by doctors and your over-the-counter choices. Please fill this out and bring it to your initial session to help save time for your needs.
16. **COUNSELING THEORIES / TECHNIQUES:** A varied array of counseling and therapy techniques may be employed or suggested during your course of treatment. You have the right to ask for explanations of suggested treatments or to refuse to comply with any suggestions made by your counselor, at which time therapy services may be terminated by mutual agreement with appropriate referrals given by the counselor.
17. **COMPLAINTS:** If you have a question concerning your counseling, please discuss this with your counselor. Credentials of all members of the counseling staff are on file, and you may request to view them at any time. Any disputes will be addressed as quickly as possible. If necessary, complaints may be formally filed with the counselor's appropriate governing Board. Addresses and/or phone numbers are available in our office, and a copy will be provided to you upon your request.
18. **CHILDREN:** Children under 16 years of age must be accompanied by an adult to the office and supervised while in the waiting area. All minor clients must remain in the waiting room during their visit to our offices except during their appointment with their counselor. We reserve the right to ask adult clients to reschedule appointment times if underage children are brought to appointment times with the purpose of leaving them unattended in the waiting areas or to include them in sessions where

sensitive information will be discussed. 4:13 assumes no responsibility for minor clients dropped off at our offices and left without a family member or guardian to supervise them prior to or immediately after their appointment. A family member or guardian MUST be present at the end of each session for counselor comments and/or to provide pick-up services for their child under the age of 16.

19. **MINOR CONSENT TO CARE:** Proof of custody or guardianship will be required to initiate counseling services for a minor child (under age 18). This proof may take the form of a finalized divorce decree, legal guardianship paperwork, or other validation of an adult's right to consent to mental health treatment for a minor child. Please bring this information with you to the parent intake session prior to your child's first individual appointment. We will make a photocopy of this information for the minor's client file. ***If this information is not available, services will not be provided.*** You will be asked to sign consent for delivery of counseling services to a minor during the parental/guardian intake session.
20. **REFERRALS:** Therapists reserve the right to suggest to a client that he/she seek services outside the office if the need is outside the scope of professional expertise or personal competency for the counselor or there is a break in the protocol or trust between counselor and client. At that time, at least three (3) community referrals will be given to the client and every effort will be made to facilitate a smooth transition of services. These referrals do not constitute a personal endorsement of the sources by the counselor. Each client is responsible for providing follow through for their continuity of care.
21. **NON-DISCRIMINATION:** 4:13 Center for Change does not discriminate on the basis of race, color, national origin, sex, religion, sexual orientation, or disability in the employment or provision of services. Clients are accepted for appointments regardless of religious affiliation or other demographic classifier.
22. **KEEP A COPY OF THIS AGREEMENT IN YOUR FILES:** Each client will be provided with a copy of this agreement. Please keep it for your records. An original signed copy will be kept in your official client file.

I HAVE READ AND UNDERSTAND THE CURRENT PROFESSIONAL PRACTICE PROCEDURES AS STATED ABOVE AND AGREE TO THEM AS A CONDITION OF RECEIVING COUNSELING SERVICES.

I hereby certify that I am entering into counseling services on a voluntary basis and recognize my right to terminate services at any time. I also certify that I have received a copy of this agreement for my records and for referral purposes should a question arise in the future concerning said procedures. I acknowledge that I have signed this document freely and not under any form of duress.

Client: _____

OR

Parent/Guardian of Minor Child Client: _____

Date: _____

Witness: _____

4:13 CENTER FOR CHANGE

PHYSICIAN INFORMATION FORM – *Please print!*

CLIENT NAME: _____

DATE: _____

PRIMARY CARE PHYSICIAN INFORMATION

DOCTOR'S NAME: _____

OFFICE PHONE NUMBER: _____

_____ FAX: _____

PSYCHIATRIST INFORMATION

DOCTOR'S NAME: _____

OFFICE PHONE NUMBER: _____

FAX: _____

OTHER REFERRING PHYSICIAN / PROFESSIONAL INFORMATION

NAME: _____

SPECIALTY: _____

OFFICE PHONE NUMBER: _____

OFFICE FAX: _____

I hereby give Bobbie Burks, PhD, LPC-S, BCPCC (dba 4:13 Center for Change) my explicit permission to contact any or all of the above medical/service providers for the purpose of coordinating care efforts on my behalf. I understand that Bobbie Burks will inform me of the need for this communication and will seek my verbal permission to make contact UNLESS the situation is of an emergent or after-hours nature. I understand it is my responsibility to inform Ms. Burks of any changes in the above information in a timely manner.

CLIENT SIGNATURE: _____

DATE: _____

WITNESS SIGNATURE: _____

4:13 CENTER FOR CHANGE

CLIENT NAME: _____

DATE: _____

MEDICATION INFORMATION: Please include prescription as well as over-the-counter medications/supplements you are now taking. Include the following information for each medication. Continue on the back OR another sheet of paper if needed.

NAME OF MEDICATION

DOSE STRENGTH

TIMES/DAY

CONDITION PRESCRIBED FOR

PRESCRIBING DOCTOR

TAKING SINCE?

MED: _____

MED: _____

MED: _____

MED: _____

MED: _____

MED: _____

4:13 CENTER FOR CHANGE

ELECTRONIC COMMUNICATION POLICIES

12/20

In the event of a life-threatening emergency, call 9-1-1 FIRST. Arrange for medical and/or law enforcement assistance to come. Then, if desired, place a voice call to the **413 Hotline at 903-787-9112** to alert your counselor of your situation.

If the need is not of a threat to life from self or others, but still of vital importance, call the 413 Hotline at 903-787-9112. The counselor will speak to you concerning your need and will assist you in determining the need for medical or legal intervention. If your counselor is not immediately available, your call will be returned as quickly as possible.

DO NOT call the Hotline for after-hours appointment setting or changes. You may call and leave a voicemail on the Office phone at 903-787-7413 OR you may call/text the Office Cell at 903-787-9112. Calls and texts of this nature will be returned in a timely manner during regular business hours, which are Monday through Friday 9:00 am – 5:00 pm.

You may also email the office at bobbieb@413cfc.com. **PLEASE NOTE that all emails sent to this address will become a part of your permanent client file AND SUBJECT TO RELEASE IF SUBPOENAED.** Questions may be answered via email, but in-depth issues need to be addressed in person. Your counselor will advise you if the issues you present in writing are more appropriate for an office visit.

Electronic communication confidentiality is an issue to consider before sending anything that may compromise your rights. Please take note of this before sending any information that could be seen by other parties. This office takes every step possible to insure your privacy, and it is essential that you take the same steps to protect your communications.

PLEASE DO NOT use the texting option for anything other than appointment requests or confirmations. It is not intended to be an outlet for the expression of feelings that are more appropriate for your next face-to-face appointment. Text messages of this nature will receive a reminder about appropriate boundaries in the counseling relationship. Abuse of the texting privilege may result in a warning, then referral options for other counselors.

Healthy boundaries are a vital part of the counseling process. These policies are not meant to be restrictive; rather, to help clarify expectations in the counselor-client relationship. Thank you for your trust and the privilege of serving your counseling needs.

I have read and agree to the 4:13 Center for Change Electronic Communication Policies as detailed above.

Client Name (Please Print) _____

Client Signature _____

WHY IT'S IMPORTANT TO KEEP YOUR APPOINTMENTS...

Aside from the obvious – that is, your progress will not be as rapid if you don't come – there are some important things to remember if you consider not keeping your scheduled appointment:

YOUR COUNSELOR MAY LOSE VALUABLE TIME INVENTORY.

When you schedule an appointment, that time slot is filled with your name and is taken out of circulation. If you **late cancel** (cancel your appointment with less than 24-hours notice) or **no-show** (just don't come, with no notice to the office staff before your appointment time), it costs your counselor time and money, for it is generally difficult to fill an appointment time with little notice. Also – you may be keeping someone else from accessing an appointment who may desire to come in that day. To help keep costs down for everyone, please call at least 24-hours in advance if you know you cannot keep your appointment.

YOU MAY LOSE MONEY.

In the agreement you signed before beginning services with your counselor, you agreed that a fee may be charged to you if you late cancel or no-show. **Please note that this fee will be enforced, including for your initial intake appointment.** That fee will be due at the time of your next appointment, or may be billed to you directly. If you are filing to insurance for reimbursement of counseling fees, YOU will be responsible for the no-show/late cancel fee, as insurance companies do not reimburse for the counselor's loss or services not rendered due to neglect or forgetfulness.

YOUR COUNSELOR LOSES MONEY.

Counselors are paid as a result of the income from appointments. If you do not keep your appointment, your counselor is faced with a loss. As described above, your appointment time is reserved for YOU...we do not book multiple clients for the same time slot as some other professionals do. A great deal of time is spent in preparing for your session, and when you do not come, that time is also lost.

YOUR COUNSELOR MAY NOT ALLOW YOU TO BOOK FURTHER APPOINTMENTS.

After a late cancel event, your counselor may choose not to allow you to return, or may at the least require that you talk to them before you set future appointments. After a no-show, you may be required to talk to your counselor before another appointment will be allowed, or future services may be refused and appropriate referrals given.

THE KEY IS...RESPONSIBILITY.

Please call our office at 903-737-7413 **IMMEDIATELY** when you know you cannot come for your scheduled appointment. Take a moment to explain your reason for not coming that day. It will be noted in your counseling file. **DO NOT** come to the office if you have a communicable disease...we trust that you will take care of yourself by being smart about your own health needs.

ALL YOU HAVE TO DO IS CALL. Your counselor values the therapeutic relationship formed with you as you work together to achieve your goals. Your consideration of the counselor's time and needs is a valuable part of that relationship. **Thank you for your help and understanding!**