



Michelle Groff, MA, LPC Intern
550 Bailey, Suite 302
Fort Worth, Texas 76107

Client Intake Information

Date: _____

Client Name: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Date of Birth: _____ Sex: _____ Race (optional): _____

Home Phone: _____ Leave message? Yes No

Office Phone: _____ Leave message? Yes No

Mobile Phone: _____ Leave message? Yes No

Email Address: _____

Marital Status: Single Married Divorced Widowed Cohabiting

Age(s) when married: _____ # of marriages: _____

Current spouse's age when married: _____ Spouse's age now: _____

If previously married, when? _____ How long? _____

Children (names and ages): _____

Custody of children from former marriage (names and ages): _____

Occupation: _____ Employer: _____

Employer's Address _____

Religious preference _____

How much influence does your religion have in your day to day living?

1 2 3 4 5 6 7 8 9 10
Not at all Very much

For what issue(s) are you requesting counseling today (please include when symptoms began and how long they have lasted)? _____

What has happened recently that has led you to seek counseling for the issue(s)? _____

Have you sought counseling or psychiatric treatment before?_____ When?_____

Present Medications (for mental health and for physical health):_____

Current Primary Care Doctor: _____ Phone: _____

Date last seen: _____

Please indicate if there is additional medical and/or personal information not previously requested that you feel should be included_____

Do you have any current or previous legal involvement such as driving under the influence, court ordered treatment, conviction of a crime, civil lawsuits, etc? If yes, explain:_____

Who referred you? _____

By signing below you certify that the information given is correct to the best of your knowledge.

Client's Signature

Date



Treatment Agreement

Restoration offers the following counseling related services: Individual, Pre-marital, Marital, Family and Group Counseling. The counselor and the client(s) will mutually decide which specific service is best suited for each person as service needs are assessed throughout the course of counseling. Counselors may recommend that the client also attend an educational class or specialized small group in conjunction with counseling through Restoration or other agencies.

I, _____, the undersigned, have received, read and understood the information contained in this Treatment Agreement. By my signature below, I voluntarily agree to receive counseling services with Michelle Groff, MA, LPC Intern through Restoration.

1. I have rights as a client of counseling services, and have received and read a description of my rights contained on the "Information for Clients" sheet. I may obtain additional information regarding rights from the Texas Department of Health Services if I so desire.
2. I understand I will be participating in the development of my treatment.
3. I understand my active participation is crucial to the outcome of counseling services received; I also understand that a favorable outcome is not guaranteed.

Client or Legal Guardian

Date

Counselor's Signature

Date

Client's emergency contact

Contact's phone #



Information for Clients

Philosophy of Counseling

The philosophy of counseling used in this office is based on the following two principles: 1) We strive to maintain the highest clinical and ethical standards, and 2) We seek to maintain Biblical integrity in our approach to therapy. While recognizing that the client’s belief system may differ from the counselor’s, there is still a commitment to recommending principles compatible with the Christian faith.

Confidentiality

All communication is confidential and your permission is necessary to release any information to outside persons except for the limitations required by the laws of the state of Texas. Exceptions to confidentiality may include (a) reasonable suspicion of incidents of child abuse or neglect, (b) incidents of elder abuse, (c) a determination that you are a danger to yourself or others, (d) collaborating with associates within this counseling group, (e) a request from you in writing, directing the counselor to give a specified individual or agency information, (f) the counselor is ordered by a court to disclose information or (g) in the event that your counselor is out of town and or otherwise unavailable and another professional is providing emergency care for his/her clients, then it is understood that this professional may need access to client files (h) I am under the supervision of Lee Long, MA, LPCs and he will have access to your information and is bound by the same confidentiality laws.

By signing below you are indicating that you have read and understood this statement and that questions about this statement have been answered to your satisfaction.

Termination of Services

Failure to appear for two consecutive appointments will forfeit the client’s time slot and the client must call to reschedule if they wish to continue counseling.

Failure to appear for appointments on a consistent basis may result in termination of counseling services by the counselor:

Client or Legal Guardian

Date

Counselor’s Signature

Date

For questions involving counseling in the State of Texas:
Texas State Board of Examiners of Professional Counselors
Texas Board of Social Work Examiners and Marriage and Family Therapists
1100 West 49th Street
Austin, TX 78756-3183
512-719-3521, 512-834-6658 or 512-834-6657



Client Payment Contract

Individual fee arrangement will be finalized at the time of the first session.

Please note that **payment is due at the time services are rendered.**

Please also note that if a cancellation for any appointment is made less than 24 hours before that appointment, **the full billing rate will be charged.** (Insurance companies do not cover the cost of cancelled sessions).

Cancellation and rescheduling can be done only by calling 871-800-0404. Cancellation and rescheduling via email is not accepted.

Although you are encouraged to call your counselor in an emergency, you will be billed at your regular rate for any calls during which you receive counseling.

If for any reason your counselor is asked to appear in court on your behalf, you will be billed at the regular rate for his time incurred in such court appearance, including travel. You will be billed ahead of time in half day increments.

All sessions are 45-50 minutes.

The fee for the initial and all subsequent sessions is \$85.00 per 45-50 minute session.

Credit cards are acceptable payment. If you wish to pay by credit card, please complete the following:

Credit card: MasterCard VISA AMEX Discover

Number: _____

Expiration Month _____ Year _____ Security Code _____

Address where bill is sent:

Street _____ City _____

State _____ Zip _____

Name as it appears on the card: _____

Restoration does not accept insurance as payment for services, although we will make every effort to provide the information necessary for you to file for reimbursement. You are responsible for payment at the time services are rendered.

By signing below you are indicating that you have read and agree to the above contract and that you also give authorization to Michelle Groff, MA, LPC Intern to release any information necessary for you to secure insurance reimbursement for fees you have paid to Restoration:

Client's Signature

Date

Counselor's Signature

Date



Release of Information

I, _____ voluntarily authorize Michelle Groff, LPC Intern to release and exchange oral and written information regarding my counseling sessions with _____ at the following phone number _____ and address:

_____.

The information will be used for the following purposes:

- follow-up care
- placement
- my treatment with Restoration or Lee Long, LPC
- insurance determinations
- other (specify) _____

The type of information to be released will be the following:

- date of treatment
- summary of treatment
- diagnosis
- psychological assessments
- other (specify) _____

I understand that my refusal to authorize release of my information does not necessarily entail termination of my treatment with Michelle Groff, LPC Intern.

I also understand that by giving my consent, as demonstrated by filling out this form, I have the right to inspect and copy the information that I have authorized to be released.

This authorization is valid until _____ (one year from the date of my signing it.)

Client's Signature

Date

Witness's Signature

Date

Parent or Guardian's Signature
(if client is under 18 yrs old or adjudicated incompetent)

Date