CROSSROADS Counseling

Adult Intake Form

Name _____ Age _____ Sex _____ Date of Birth _____

Street Address _____ Phone (h) _____

City, State, Zip _____ Phone (w) _____

Email address _____ Phone (cell) _____

For confidentiality, when and where do you prefer to be reached? _____

Current Marital Status: Single ____ Engaged ____ Married ____ Separated ____ Divorced _____

Date of Current Marriage/Separation _____ Number of Marriages _____

Spouse's Name _____ Date of Birth _____

Number of children and ages _____

Presently living with: Parents _____ Spouse _____ Roommate _____ Alone _____ Other _____

Emergency Contact: Name _____ Phone _____ Relationship _____

Who referred you (or how did you hear about us)? _____

Counselor Preference (if none leave blank) _____

Please list specific days/time of day for your appointment availability (Day of the week, morning, afternoon, evening) _____

What type of counseling are you seeking? Please select one:

Type	Description	Forms Required
□ Individual	1 on 1 counseling	1 intake form
□ Family	2 or more family members	1 intake form per person over 18 years old
□ Relationship	Couples who are dating	1 intake form per person (2 forms total)
□ Premarital	Couples who are engaged or considering marriage	1 intake form per person (2 forms total)
□ Marital	Couples needing marital guidance	1 intake form per person (2 forms total)

Reasons for seeking help

What concerns have led you to pursue counseling? _____

_____

What are your concerns causing the most problems for you? Check all that apply:
□ Home □ Work □ Relationships □ Marriage □ God □ Other _____

When did your present concern begin to be a problem for you? _____

Have any concerns about you been identified by others? _____

Please rate the severity of your present concerns on the following scale. Check one:
□ Mild □ Moderate □ Severe □ Totally Incapacitating

Please indicate which of the following areas are problems currently for you:

□ Under too much pressure/feeling stressed	□ Loss of appetite/increased appetite
□ Excessive anxiety or worry	□ Issues with food and/or weight
□ Feeling lonely	□ Lacking self-confidence
□ Angry feelings	□ Difficulty making friends
□ Angry outbursts	□ Delusions
□ Concerns about finances	□ Hallucinations
□ Feeling "numb" or cut off from emotions	□ Hearing voices
□ Insomnia (no sleep) or hypersomnia (sleep all the time)	□ Feeling that people are "out to get you" or that you're being watched
□ Abuse of alcohol and/or non-prescription drugs	□ Inability to concentrate while at school/work
□ Feeling as if you would be better off dead	□ Feeling distant from God
□ Feeling manipulated or controlled by others	□ Feeling sexually attracted to members of your own sex
□ Difficulty making decisions	□ Nightmares
□ Loss of interest in sexual relationships	□ Excessive fear of specific places/objects
□ Loss of interest in usual activities/lack of motivation	□ Obsessions or compulsions with specific activities
□ Concerns about physical health	□ Inability to control thoughts
□ Blackouts or temporary loss of memory	□ Feeling trapped in rooms/buildings
□ Crying spells	□ Other _____

Medical/Health Information

How would you rate your current physical health? □ Excellent □ Good □ Fair □ Poor

Date of last physical examination _____

Are you currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems) □ Yes □ No

If yes, please explain _____

Medication Name Over the counter or Prescription	**Dosage**

Previous hospitalizations for medical reasons:
Date _____ Reason _____

Date _____ Reason _____

Have you ever been hospitalized for psychiatric purposes? □ Yes □ No
If yes, please explain including name of hospital, location, and dates _____

_____

Permission to contact previous counselor: □ Yes □ No
List names of any previous counselors/therapists, including dates and a contact number _____

_____

How do you feel about the results of your previous counseling? _____

_____

What do you hope to gain from counseling? _____

_____

Occupational/Educational Information

Occupation _____ Employer _____ Annual Income _____

If currently a student:
Field of Study _____ □ Part time □ Full time

Institution, University, or College _____

Religious Background (optional)

Do you believe in God? □ Yes □ No Religious preference _____

What church do you currently attend? _____

Are you a member of Crossroads? □ Yes □ No

How much influence does your religion have on your day-to-day activity? _____

_____

_____

I certify that this information is true to the best of my knowledge.

_____ _____

Signature Date

Crossroads Counseling Agreement

Please read carefully before signing the last page of this agreement.

Description of Counseling
Crossroads Counseling is Christ-Centered counseling and adheres to the Code of Ethics prescribed by the American Association of Christian Counselors available to view on www.aacc.net

What to Expect for the First Session
Once you have made contact with counseling@crossroads140.com, your individual counselor will reach out to you to schedule your first appointment. (For subsequent appointments, contact your individual counselor directly.) Your individual counselor may or may not request a longer first session in order to review and discuss intake paperwork. Please bring the following to your first session: the appropriate Intake Forms (one for each Adult or Child), the Crossroads Counseling Agreement Informed Consent Signature Page, the Credit Card Authorization Form, a Signed Individual Privacy Statement, and if applicable, a Signed Privacy Statement for Couples and Families.

> **For Child/ Minors**
> In addition to the required paperwork listed above, please bring appropriate custody documents. For the initial session, the presence of both parents is essential to optimize the counseling experience, to acknowledge each other's informed consent, and to support the minor in the counseling process.

Sessions
Counseling sessions are generally 50-minutes in length. Part of this time may be used for updating client progress. Counselors will be assigned by the director based upon a variety of factors including client availability, counselor availability, and counseling goals.

Insurance
We are not able to accept any type of health insurance.

Payment
Payment is due at the beginning of each session. Crossroads Counseling accepts cash, checks or credit card. A Credit Card Authorization Form is kept on file to be used in accordance with our Cancellation Policy. *Checks should be made payable to Crossroads Counseling. Please also list the name of your counselor on the "Memo" line of the check.* Accounts must be kept current in order to continue counseling.

Appointment Fees
Crossroads Counseling has a set fee of $70 for each session of individual, couples', family or group counseling.

Cancellation Policy and Fees
If you need to cancel and/or reschedule your appointment you must notify your counselor via text or a phone call 24 hours before your scheduled appointment time. You will be subject to a full charge for your scheduled session if you fail to contact your counselor in advance. The credit card on file will be charged. Exceptions determined by the individual's counselor are made in emergency situations only.

Inclement Weather
Crossroads Counseling follows the closures of the Carroll County Public School system when cancelling for inclement weather. If the school or evening activities are cancelled, counseling appointments will be cancelled for that day. In the event that the school system is closed but the offices at Crossroads Church are open, arrangements to have a counseling session can be made on an individual basis between the counselor and the client. Cancellation fees will not be charged if the inclement weather policy is in effect.

Confidentiality
To release information without your consent would violate commonly accepted codes of counseling ethics. There are situations, however, in which we are required by law to reveal information without your consent (refer to Privacy Statement for more information). Counselors will conceal your personal identity during supervisory counseling meetings. The purpose of supervision is to ensure quality of care.

Referral Policy/ Disclaimer
Clients will be referred outside of Crossroads Counseling when treatment required is beyond the scope of care offered. Though Crossroads Counseling strives to be responsible and professional in the referral procedure, it is your full right and responsibility to select the professional of your choice. Crossroads Counseling is not liable for any services provided or not provided by the referred professional.

Termination of Counseling
Counseling services may be terminated when the counselor and the client mutually agree to the termination. If for any reason you feel your best interests are not being served, you have the right to terminate counseling at any time without any moral, legal, or financial obligations other than those already accrued.

CROSSROADS Counseling

Crossroads Counseling Agreement & Informed Consent

Name of Person Giving Consent _____

Your Relationship to the Client

□ Self □ Stepparent □ Grandparent
□ Parent □ Guardian □ Other _____

I, _____, consent to the Biblically- based counseling services offered by Crossroads Counseling.

_____ _____
Signature Date

If consenting for a minor (17 years or younger) please complete the following section:

Name of Child _____ Date of Birth _____

Does the consenting adult have legal custody of the child: □ Yes □ No
If yes, is it □ joint custody OR □ individual custody?
If no, who is the legal guardian? _____

CROSSROADS Counseling

Crossroads Counseling Center, LLC
Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us at bediecounseling@crossroads140.com. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CVV Code: _____
Cardholder Billing Address: _____ _____ Cardholder Email (for receipt): _____

I, _____ authorize Crossroads Counseling to charge my credit card above for agreed upon purchases. I understand that there is a $2 processing fee, and that my information will be saved to file for future transactions on my account.

_____ _____

Signature Date

CROSSROADS Counseling

Privacy Statement

Notice of Policies and Practices to Protect the Privacy of Your Health Information
This Notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures for Treatment and Health Care Operations
Crossroads Counseling may use or disclose your Protected Health Information (PHI) for treatment purposes with your consent. To help clarify these terms, here are some definitions:

> "PHI" refers to information in your health record that could identify you.
>
> "Treatment" is when Crossroads Counseling provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when Crossroads Counseling consults with another health care provider.
>
> "Use" applies only to activities within the Crossroads Counseling office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
>
> "Disclosure" applies to activities outside of the Crossroads Counseling office, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization
Crossroads Counseling may use or disclose PHI for purposes outside of treatment when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when Crossroads Counseling is asked for information for purposes outside of treatment, Crossroads Counseling will obtain an authorization from you before releasing this information. Crossroads Counseling will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes Crossroads Counseling has made about conversations during a private, group, joint or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that Crossroads Counseling has relied on that authorization.

Uses and disclosures with Neither Consent nor Authorization
Crossroads Counseling may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If Crossroads Counseling has reasonable cause, on the basis of professional judgment, to suspect abuse of children with whom Crossroads Counseling comes into contact in a professional capacity, Crossroads Counseling is required by law to report this to the ACS.

Adult and Domestic Abuse: If Crossroads Counseling has reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), Crossroads Counseling may report such to the local agency which provides protective services.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made about the professional services Crossroads Counseling provided you or the records thereof, such information is privileged under state law, and Crossroads Counseling will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious threat to Health or Safety: If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and Crossroads Counseling determines that you are likely to carry out the threat, Crossroads Counseling must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

Patient's Rights and Counselor's Duties:

Patient's rights:

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Crossroads Counseling is not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communication of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing Crossroads Counseling. Upon your request, Crossroads Counseling will send communications to another address or phone number.)

Right to Inspect and Copy: You have the right to inspect or obtain a copy of PHI in Crossroads Counseling's mental health record for as long as the PHI is maintained in the record. However, Crossroads Counseling reserves the right to deny your access to PHI under certain circumstances. On your request, Crossroads Counseling will discuss with you the details of the request and denial process.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. However, Crossroads Counseling reserves the right to deny your request. Upon your request, Crossroads Counseling will discuss with you the details of the amendment process.

Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization. On your request, Crossroads Counseling will discuss with you the details of the accounting process.

Counselor's Duties:

Crossroads Counseling is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.

Crossroads Counseling reserves the right to change the privacy policies and practices described in this notice. Unless Crossroads Counseling notifies you of such changes, however, Crossroads Counseling is required to abide by the terms currently in effect.

If Crossroads Counseling revises policies and procedures, Crossroads Counseling will provide you with a revised notice by mail or in person.

Complaints

If you are concerned that Crossroads Counseling has violated your privacy rights, or you disagree with a decision Crossroads Counseling made about access to your records, please bring this to the attention of the Director of Crossroads Counseling Services in writing.

Effective Date, Restrictions and Changes to Privacy Policy

This notice will be in effect as of January 1, 2019

CROSSROADS Counseling

Privacy Statement Acknowledgement Form

This certifies that I have received from my counselor at the Crossroads Counseling Center a copy of the notice of policies and practices to protect the privacy of my health information.

_____ _____

Signature of Client Date

_____

Printed Name

_____ _____

Signature of Parent or Legal Guardian (If Client is under 18) Relationship to Client

_____ _____

Printed Name Date

CROSSROADS Counseling

Privacy Statement for Couples & Families

SPECIAL CONSIDERATIONS FOR COUPLES AND FAMILY COUNSELING CLIENTS

When Crossroads Counseling agrees to treat a couple or a family, Crossroads Counseling considers that couple or family (the treatment unit) to be the patient. If there is a request for the treatment records of the couple or the family, Crossroads Counseling will seek the authorization of all members of the treatment unity before Crossroads Counseling releases information to their parties.

Crossroads Counseling may see a smaller part of the treatment unit for one or more sessions. These sessions should be seen by you as a part of the work that Crossroads Counseling is doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions, understand that generally these sessions are confidential in the sense that Crossroads Counseling will not release any information to a third party unless required by law to do so or unless Crossroads Counseling has your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, Crossroads Counseling would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, Crossroads Counseling may need to share information learned in an individual session with the entire treatment unit if Crossroads Counseling is to effectively serve the unit being treated. Crossroads Counseling will use the best judgment as to whether, when and to what extent we 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 would like kept completely confidential, you might want to consult with an individual counselor who can treat you individually.

This "no secrets" policy is intended to allow Crossroads Counseling 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 Crossroads Counseling is not free to exercise clinical judgment regarding the need to bring this information to the family or the couple during their counseling, Crossroads Counseling might be placed in a situation where we 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 _____ being seen, acknowledge by our
(couple/family or other unit)
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 _____, and that we
(counselor)
enter couple/family counseling in agreement with this policy.

Signature _____ Date_____

Printed Name _____

Signature _____ Date_____

Printed Name _____

Signature _____ Date_____

Printed Name _____

Signature _____ Date_____

Printed Name _____

Use additional date and signature lines as is necessary. If someone is signing in a representative capacity, such as a parent or a court-appointed guardian or conservator, such capacity should be stated and the person being represented should be specified.