General Information

Date:_____

Name:_____
Last First Middle Initial

Name of Spouse or Parent: _____

Address:_____

City:_____ **Zip**:_____

Email : _____

Home Phone:_____okay to contact __Yes __No
Cell Phone:_____
Work Phone:_____ okay to contact__Yes __No

How did you hear about my services? _____ _____ Internet Website
If phone book , which one? ____ Southwestern Bell Yellow Pages _____ YellowBook Phonebook

Nearest Relative or Friend to Contact in Case of Emergency:
Name: _____ Phone: _____

Education Level: ____Under 12th grade _____High School ____College
Religious Affiliation: _____
Gender: ___M ___ F Marital Status:_____
Birthday :_____
Social Security #:_____-_____-_____
Occupation:_____
Status: ____Full Time ____Part Time ___Retired

Description of Problem: _____
_____

Members of Household:

Name:	Age:	In/Out:	Attending First Session:

Are you currently using medications of any type?:_____Yes_____No
If so, please list the name, purpose, and length of time of medications:
_____

Phil Armour, M.MFT, LPC, LMFT

Client Information

A. Name _____

Problem/s wanting help with:

_____Marital Stress	_____Adult Incest Survivor
_____Divorce Issues	_____Incest- Child
_____Spousal Abuse	_____Suicide Threat
_____Family Death	_____Chemical Dependency
_____Rape	_____Disability Stress
_____Pre-marital	_____Child's School/Home Behaviors

Other: _____

_____

B. Family Structure: (Check One)

_____Married	_____Not married: living alone
_____Separated	_____Not married: living w/ extended family
_____Divorced	_____Grandparent & Child w/ absent parent
_____Remarried	_____Co-Habitation w/ unmarried partner

Total number of marriages for you: _____

Total number of marriages for your spouse _____

Is there a lawsuit pending, or is there a probability of a lawsuit being filed regarding this problem? _____Yes _____No

If yes, please explain _____

_____

- Mark all Family Subsystems that you believe are involved in presenting problem:
  ___Individual ___Marital _____Parental _____Extended

- Have you or any other family member ever been involved in therapy or any other type of counseling program? _____Yes _____No
  If yes, when: _____where: _____
  reasons: _____
  _____

- Have you or any other family member ever been hospitalized for any mental health reasons?
  ___Yes ____No
  If yes, who _____when _____
  where _____

- Have you or any other family member ever been, or are you now being treated for any type of chemical dependency abuse? _____Yes _____No
  If yes, who _____where _____
  length of treatment_____

- Are you or any other family member at the present time using any type of chemical substances?_____Yes _____No
  If yes, who _____
  Please indicate what substance(s) (drugs and/ or alcohol) _____
  _____
  _____
  How frequently are these substances used? _____
  _____

- Have you or any other family member ever been arrested/ committed a crime?
  _____Yes _____ No
  If yes, who_____ when _____
  For what _____
  Outcome of situation_____
  _____
  _____

- Have you or any other family member ever attempted suicide?
  _____Yes _____No
  If yes, please indicate whom_____when _____
  Was treatment for counseling received? _____Yes _____No

- Is your present sex life satisfactory?_____Yes _____No
  Please note any sexual concerns you, your spouse or mate may have: _____
  _____
  _____

- Religious affiliation: _____

- Church attending:_____how often: _____

- Important cultural or religious information: _____
  _____
  _____

- If student:
  School Problems? _____Yes _____No
  If yes, what _____
  _____
  _____
  _____
  Grade in school _____
  School attended _____

- Check any of the following behaviors that apply to your or any of your family members:

_____Overeating	_____Procrastination
_____Aggressiveness	_____Drink too much
_____Odd Behavior	_____Loss of control
_____Sleep disturbance	_____Work too hard
_____Dizziness	_____Smoking
_____Impulsive reactions	_____Eating problems
_____Crying	_____Compulsion
_____Vomiting	_____Bladder/ bowel control
_____Nervous tic	_____Concentration difficulties
_____Phobic Avoidance	_____Seeing hearing/things

INFORMED CONSENT

Phil Armour, M.MFT, LPC, LMFT

I am sincerely glad that you are here. I am committed to providing you with quality service. You will be learning about counseling services and policies during your first session, and you will have the opportunity to ask any questions you may have. This document is designed to insure that you understand your rights and our professional relationship.

THEARPIST BACKGROUND AND ORIENTATION

Phil Armour holds a master's degree in marriage and family therapy from Abilene Christian University. He is licensed both as a Licensed Professional Counselor and Licensed Marriage and Family Therapist. He has worked well over four years in the East Texas area providing psychological services as a Christian counselor. He has collaborated with several agencies and developed a vast network of resources to assist families. In his work with individuals and families, he incorporates systems theory with experiential training to encourage change. Mr. Armour utilizes a faith-based approach as a foundation without excluding individuals from other backgrounds. He has worked with individuals with presenting problems as diverse as: depression, anxiety, sexual abuse, violence, marital issues, parenting problems, divorce, grief, stress management, jealousy/rage, and work-related problems.

Phil Armour, LPC, LMFT takes insurance, Medicaid, and private pay.

YOUR RIGHTS AS A CLIENT

1. You have the right to decide not to receive psychotherapy from me. If you wish, I will provide you with the names of other qualified psychotherapists.

2. You have the right to end therapy at any time without any moral, legal, or financial obligation other than payment of fees for services rendered.

3. You have the right to ask any questions about the procedures used during therapy. If you wish, I will explain all therapeutic procedures and their rationales to you.

4. You have the right to prevent electronic recording of any part of the therapy sessions. Occasional tape recording (video and/or audio) of therapy sessions is used for the purpose of review in order to maximize the benefit of your therapy time. However, you have the right to withdraw your permission to record at any time.

5. You have the right to review your records at any time.

6. You have the right to have information revealed in therapy kept strictly confidential, except as described in the section below.

7. You have the right to have any part of your record in your files released to any persons or agencies you designate. I will tell you at the time whether or not I think making the record public will be harmful to you.

8. You have the right to address any complaints against any Licensed Professional Counselor (LPC) to the Texas State Board of Examiners of Professional Counselors, 1100 West 49th Street, Austin, TX 78756-3183, (512) 459-2900. You may also address complaints to the Texas State Board of Examiners of Marriage and Family Therapists at the same address.

NATURE OF COUNSELING

I accept in my private practice only those clients who I believe have the capacity to resolve their own problems with my assistance. My desire is to help you resolve the problems that brought you in for counseling as quickly as possible. Some clients need only a few counseling sessions to achieve their goals while others may require months to overcome their difficulties. A few clients may need a long-term relationship with me in order to function adequately in the outside world. When counseling is successful, you should feel that you are able to face life's challenges in the future without regular contact with me. Of course, as situational and developmental issues arise in the course of living, I will always be happy to see you for a counseling checkup.

Although our sessions may be very intimate emotionally and psychologically, it is important for you to know that we have a *professional relationship* rather that a personal one. Our contact will be limited to the paid sessions you have with me. While I appreciate invitations to social gatherings and gestures of caring such as gift from clients, it is inappropriate for me to relate to you in any way other than in the professional context of our counseling sessions. You will be best served if our relationship remains strictly professional and if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling experience. However, it is important for you to remember that you are experiencing me only *in my professional role.*

In a community like the Longview area, it is inevitable that I will see some clients or former clients at community, church, or social functions. In such cases, I leave it to the client or former client to set the tone of our interaction in that setting. I will not indicate any prior knowledge of you, and in no case will I say anything that would indicate to others present that you have had a counseling relationship with me. This is done in order to preserve confidentiality regarding your counseling.

CONFIDENTIALITY

All information about your treatment is kept with strict confidentiality, except for the conditions listed below. In order to protect your confidentiality.

PROCEDURES
The following procedures will be adhered to:

1. Written, telephone, or personal inquiries about you will not be acknowledged. You must sign a release of information before any information about you is given to anyone outside the clinic. Even then, I may advise you to withhold information if I feel it is in your best interest.

2. All records, tapes and other identifying materials are kept confidential.

3. When families are involved in family therapy (this does not apply to individuals in therapy), they agree to a modification of the traditional rules of confidentiality in order to allow the therapist the freedom of inquiry necessary to optimally serve them. Specifically, the therapist must be given the freedom to reveal to other family members what has been told by one family member so that the therapist will have full opportunity to explore all points pertinent to the therapeutic process. While I will respect your privacy and will not automatically reveal all information provided, I reserve the right to make such revelations if I consider them warranted for the purpose of aiding the family in overcoming presenting problems which brought them into therapy.

4. When working with children, adolescents and teenagers it is extremely important to build trust. Therefore anything told to me in the session with the child will be held in strict confidence unless given express permission by the child to share it with the parent(s).

5. **Confidentiality and privileged communication are the rights of all clients, and we exercise every effort to maintain these rights. Information included in your file (e.g., intake form, progress notes, assessment information, etc.) is shared only with Mr. Armour and his filing staff. Should information be requested from a source outside these people, the client's written permission will be requested before such information is sent. However, I may release information without your consent if the law requires that me do so. This includes:**
    1. **where a court order is received,**
    2. **if there is an emergency that threatens the client's life or the life of another or if there is a probability of immediate mental or emotional injury to the client, or**
    3. **if there is evidence of child abuse and/ or neglect.**

   I will make every effort possible to notify the client in advance before such a release of information takes place. _____ Initial

THE RISK OF COUNSELING

The greatest risk of counseling is that it may not by itself resolve your problem(s) or concern. Thus, I assess progress on a week-to-week basis. Chronic non-improvement is treated as a reason for immediate referral. Unusual risk in any therapy assignment will be described at the time to the best of the therapist's ability and alternatives will be offered. There my be a worsening of symptoms before improvement is seen. This is a normal part of the counseling process. Also, be aware of the risk of only one person attending may adversely affect the marital relationship. That is why we encourage the entire family to participate in family or marital therapy.

I have chosen to discuss the risks of counseling out of an ethical commitment to help you make an informed choice to participate with me in addressing your concerns. In fact, this commitment will carry through your counseling. At any time you may ask why I am gathering information or utilizing a new approach. I will be happy to explain the purpose behind my techniques.

APPOINTMENTS FOR THERAPY

It is your responsibility to notify me at least 24 hours in advance if you will not be able to keep your scheduled appointment. **If no notice is given, or if less than 24 hours notice is given, to cancel appointment, you will be charged your regular session fee.** _____ Initial

TERMINATION OF THERAPY

You may terminate therapy in any of the following ways:

1. Verbal or written notification.
2. Missing 2 consecutive appointments without 24-hour notice.
3. Threatening or abusive remarks or behaviors.
4. Not paying agreed upon fees for services rendered.
5. Failure to follow my recommendations regarding crucial issues of physical health, safety, and crisis situations (i.e. medical referrals, suicide interventions, etc.)

Of course, the client may choose to leave therapy at any time, but this is best accomplished in consultation with the therapist. If the client is dissatisfied with the course of therapy, I encourage you to talk with me. I will try to resolve the problem or will provide you with referrals to other appropriate professionals.

SUBPOENAS TO COURT

In family disputes which result in legal actions by one or more family members, it is almost always inappropriate for Phil Armour to be subpoenaed to testify since his focus is on helping families and individuals to find their own strengths and resources to overcome various crises. The focus of Mr. Armour's work in NOT on the kinds of assessments that are appropriate in legal disputes such as child custody battles. Therefore, all family members participating in counseling agree that they will not have their attorney's subpoena Mr. Armour to testify in such cases. If Mr. Armour is subpoenaed to testify, his fee is $150/ hour (1-hour minimum) plus expenses paid in advance of his testimony.

CRISIS

In a crisis situation the therapist will be reached through the answering service (24-hour coverage). Call the office number (753-2117) and let the service know it is a crisis and they will reach the therapist as quickly as possible. If the crisis is extreme and/or danger is imminent, call the police or any of the following resources which seems appropriate:

Crisis Line (through Sabine Valley): 1-800-832-1009
Women's Center: 757-9308
Kilgore Crisis Center: 984-2377
Good Shepherd: 236-2000;
Longview Regional: 758-1818

FEES

The fee for psychotherapy is $150 for the initial visit and $100 per 50-minute visit thereafter.

Telephone consultations (during regular business hours) are charged the same rate as office sessions. However, insurance will not usually pay for phone sessions, so the full charge ($100 per 50min) is the responsibility of the client. __ Initial

Emergency consultations (office or phone) at non-office hours are $2.00/minute. The client will be charged for travel time to and from the office for emergency consultations. Insurance companies do not usually pay for phone consultations or for travel time by the therapist. The client's totally responsible for such fees. __ Initial

Fees are due at the beginning of each session. If you do not keep your agreements to pay the agreed upon fees in a timely manner, the therapy will be terminated. Any balance due must be paid before returning to therapy.

INSURANCE

The therapists will file with your insurance company for you. This does not negate the fact that you are solely responsible for your balance. Most health insurance companies will require that I diagnose your mental health condition and indicate that you have an illness. I will inform you of the diagnosis I plan to render before I submit it to the insurance company. Any diagnosis made will become part of your permanent insurance records.

If, after 2 months of filing with your insurance, they have not rendered payment to the therapist it will be your responsibility to pay the balance owed and be reimbursed by your insurance carrier. ____Initial

CONSENT FOR SERVICES

I understand that there is no guarantee that therapy will resolve my problem(s) and that there are risks involved in therapy. I will take responsibility for discussing with my therapist either the absence of meaningful change or discomfort that I may have with the course of therapy.

I understand the confidentiality policies previously stated and agree to them. Particularly in regard to the limits of confidentiality relative to other family members in family counseling.

I authorize the release of my records to my insurance carrier or other referring agencies if requested by them. If I have been referred by a physician, I authorize the release of records to them upon request. RECORDS WILL NOT BE RELEASED TO CLIENTS. I understand that records provided to insurance carriers include a diagnostic category.

I understand that it is my responsibility to pay fees for services rendered. Any dispute with my insurance carrier over payment is my responsibility to resolve and does not relieve me of my obligation to pay Mr. Armour

During the course of my treatment, I hereby authorize payment directly to Mr. Armour the medical benefits.

I understand that appointments not cancelled with 24 hours notice will be billed directly to me, not my insurance carrier.

I understand that the focus of counseling with Mr. Armour is not on the kind of assessment relevant to legal disputes such as child custody litigation, and I therefore agree that I will not have attorneys subpoena Mr. Armour in such disputes.

I have read and understand the statements on the previous pages of the Client Information Booklet. My signature below indicates that I give my full and informed consent to receive services.

_____ _____

Client signature Date