Shiloh Counseling Services

12402 Slide Road, #402
Lubbock, Texas 79424
(806) 794-3232

INTAKE FORM

Your Name: **Date of Birth:**

_____

All other family members who may attend or participate in counseling:
Name: **Date of Birth:** **Relationship:**
_____

_____

_____

_____

Primary reason for seeking counseling: _____

Your Address: _____
(Street address) (City) (State) (Zip)

Contact phone numbers: _____
May we leave messages? ○ yes ○ no May we text? ○ yes ○ no

Referred By: _____
May we let them know that you came? ○ yes ○ no

Have you previously received any type of mental health services (Counseling, therapy, psychiatric services, psychiatric inpatient hospitalization, etc.?)

- ○ No
- ○ Yes, previous therapist/practitioners:

  _____

In case of emergency, whom should we contact?

Name: _____Phone:_____

Financially Responsible Party: *(Will receive billing statements if necessary)*

Name: _____Phone:_____

Billing Address:_____

Scheduling of Appointments:
Your therapist respects your time and endeavors to always be on time to give you your full session. Your therapist asks that you give mutual respect for his/her professional time. A scheduled appointment reserves that time only for you. If you need to change your appointment time please allow 24 hours prior notification. The full session fee is charged for missed appointments that are not cancelled. One half of the session fee is charged for late cancellations, with the exception of emergencies or illness.

____Initials

Subpoenas and Expert Witness Testimony:

Clients should consider whether or not they want to issue a subpoena for a therapist to testify in court. The process is always expensive to the client, and there is no guarantee that what the therapist will say will be of benefit to the client's case. In some cases a therapist's testimony may be detrimental to the client's case. This is why the decision to subpoena a therapist should be seriously considered. Expert Witness Testimony in children's custody cases is always on behalf of the child or children. The testimony will be the therapist's honest opinion about what is in the child or children's best interests, regardless of who has subpoenaed the therapist.

If the therapist is subpoenaed to be in court (civil or criminal) regarding an issue with a client, this will necessitate that the therapist clear his/her schedule to be "on call" for the court appearance. The charge for this is a minimum nonrefundable fee of $1000, payable in advance, regardless of whether the therapist actually testifies or appears in court. The first $1000 applies to a minimum of one day set aside to be on call for a court appearance. Expenses the therapist may incur such as parking, travel time, telephone calls, and time spent preparing documents will be charged at the standard hourly rate and are in addition to the $1000 minimum fee. If the therapist is required to be on call beyond the first day for a court appearance, an additional $1000 minimum fee will be incurred, for each additional day. In other words, a $1000 minimum fee will be charged for any portion of a day in which the therapist is required to be "on call" to testify in court, whether the therapist actually testifies or not.

____Initials

Emergencies:

Medical and/or psychiatric emergencies should be directed to 911 or the emergency room if life or safety is threatened. If you would like to speak to your therapist about your emergency, please leave a message. The therapist will return your call as soon as possible during regular working hours. However, if this is a life-threatening emergency, please call 911 or go to the nearest ER; do not wait for your therapist to return your call.

____Initials

Telephone / Out of office meetings:

Whether in crisis or not, a client may occasionally want to discuss an issue on the phone. If a phone call with your therapist lasts more than 15 minutes, there is a minimum fee of ¼ the session fee. If the phone call lasts 30 minutes or longer, the client will be billed at a rate of ¼ the session fee per 15-minute increment.

If a client wants the therapist to meet, speak with, or correspond in any way with any other person to include but not limited to an attorney, school, probation officer, CPS worker, physician, etc., the client will be billed for the therapist's time in the same manner as above.

____Initials

Confidentiality:

You have the right to confidential mental health care *except* in cases where the therapist believes you might cause harm to yourself, to someone else, or if child or elder abuse/neglect is suspected. In these cases, the therapist has a duty by law to file a report with the appropriate authorities. Also, therapists are required to testify when commanded to do so by a court ordered subpoena.

If you run into any of our therapists outside of the office, they will not acknowledge you. They do this to ensure your right to confidentiality. However, if you want to greet, visit with, or introduce your therapist to your friends or family as a friend or your therapist, that is up to you. The therapist will let clients take the lead in these situations.

____ Initials

Clinical and Therapist Information:

The primary commitment of Shiloh Counseling Services is to provide you with quality counseling services. However, no therapist can guarantee that counseling services will be effective for you. This disclosure and consent statement is intended to convey pertinent information regarding our services, allowing you to make choices based on correct information. All of our therapists are licensed or board certified, or they are working toward licensure under an approved supervisor. We endeavor to maintain a high level of competence and we adhere to professional, legal, ethical, and moral standards. We seek to integrate emotional, spiritual, physical, relational, and mental elements in the therapy process. A variety of techniques and approaches are used. If you have any further questions regarding your therapist's training or professional approach, please feel free to ask your therapist.

____Initials

CONSENT TO TREATMENT

I have read and fully understand the disclosure and confidentiality information stated above, and I give my consent to Shiloh Counseling Services to be assessed and treated. I will be provided a copy of this disclosure and consent at my request.

_____

_____

_____

Signatures of all family members age 18 and above Date

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www.ShilohCounselingServices.com

SHILOH COUNSELING SERVICES

PARENTAL OR GUARDIAN CONSENT TO TREATMENT

This page should be filled out by the legal guardian or custodial parent of any minor child, age 17 or younger.

Please list all minors who may attend counseling:

Name: Date of Birth:

_____

_____

_____

Parental Consent:

I, as legal guardian of the client or clients listed above, give my authorization for Shiloh Counseling Services to provide professional counseling for this/these minor child(ren).

_____

Legal Guardian Signature Date

For Parents/guardians who share custody:

It is your responsibility to ensure that you are complying with the custody orders that are in place regarding authorizing psychotherapeutic services for your minor child.

____Initials

It is the custodial parent's responsibility to inform the non-custodial parent that the minor is receiving counseling, and to make available Shiloh Counseling Services' contact information.

____Initials

Shiloh Counseling Services
Appointment Reminders

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.

Client name: _____

Where would you like to receive appointment reminders? (check ONLY ONE)

_____ Via a text message on my cell phone (normal text message rates will apply)

Your cell phone number: _____

Second cell phone number (optional): _____

_____ Via an email message

Your email address: _____

_____ Via an automated telephone voice message to my home (or cell) phone.

Home (or cell) phone number: _____

_____ None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

As technology is never 100% reliable, the appointment reminder system is not fail proof. The client remains responsible for missed appointments should such failure occur. Missed appointment fees will still apply.

___Initials

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

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Signature Date

Shiloh Counseling Services

Fee Policy for Services:

Payment is expected in full at the time of services.

Please check one:

- ☐ I will pay the full rate at each session. (Not applying for sliding scale)
- ☐ I will submit my financial information to apply for sliding scale rates:

  Household Income, including all family member's wages, child support, disability, SSI, etc.

  Circle one: Annual Monthly $_____

  Number of family members: _____

Your Therapist will fill this section out during your first appointment.

Fees for services:

One Hour (50 to 60 minutes) ……..$_____

Half Hour (20 to 30 minutes)……..$_____

Hour and a half (75 to 90 minutes) ……..$_____

Two hour (100 to 120 minutes)……..$_____

Missed Appointment fee ……..$_____

Late Cancellation fee ……..$_____

Client Signature:_____Date:_____

Therapist Signature: _____Date:_____

Shiloh Counseling Services
Online Appointment Scheduling

You can enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit www.ShilohCounselingServices.com to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system.

This is optional! You do not need to fill this page out if you do not want this option.

Your name:
_____

Requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

Requested password: |__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

_____
Signature Date

TEAR HERE ~~ TEAR HERE ~~ TEAR HERE ~~ TEAR HERE ~~ TEAR HERE

Keep This Portion for your Records

To Schedule or cancel an appointment with your therapist, follow these steps:

1. Go to www.ShilohCounselingServices.com.
2. Click on the "Meet our Therapists" tab.
3. Click on your therapist's name.
4. Click on the "Set Appointment with" link under your therapist's name.
5. Enter your login name and password in the "*Have a Password? Log In:*" area.

Requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

Requested password: |__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)