METROPLEX COUNSELING

A Center for Biblical Soul Care

209 N. Industrial Blvd #237
Bedford, TX 76021

2501 Parkview Dr # 315C
Fort Worth, TX 76102

817-571-4110
www.metroplexcounseling.com

MARRIAGE INTAKE

SECTION ONE: COUNSELEE INFORMATION: **Today's Date:** _____

Husband's Name: _____

Date of Birth:_____ Age: _____

Wife's Name: _____

Date of Birth:_____ Age: _____

Home Address _____

City_____State_____Zip _____

Home Phone ( )_____

Husband's Occupation:_____Employer:_____

Work Phone: ( )_____Cell ( ) _____

Primary email address _____

Secondary email address _____

Wife's Occupation:_____Employer:_____

Work Phone: ( )_____Cell ( )_____ Primary email address _____

Secondary email address _____

Wedding Anniversary Date:_____Years Married: _____

Children with Current Spouse (names/ages) _____

_____

Husband's Previous Marriage(s): First (Years___) Second (Years____) Third (Years____) Fourth (Years___) Children (names/ages) by Previous Marriage(s) _____

_____

Wife's Previous Marriage(s): First (Years___) Second (Years____) Third (Years____) Fourth (Years___) Children (names/ages) by Previous Marriage(s) _____

_____

CONTACT PREFERENCES:

Please check any of the following at which you prefer **NOT** to be contacted or receive written material:
Home Phone ( ) Husband Work Phone ( ) Husband cell ( ) Wife Work Phone ( ) Wife cell( )
Primary email ( ) Secondary email ( ) Home Address ( )

Emergency contact name and phone# _____

SECTION TWO: PHYSICAL HEALTH:

Husband's General Physical Health (please rate yourself**):**

Very good Good Average Poor Improving Declining

If not very good, please explain.

List all illnesses, allergies, injuries or handicaps that presently affect you.

Medications: Please list any medications you are currently taking.

1. _____ Purpose: _____
2. _____ Purpose: _____
3. _____ Purpose: _____
4. _____ Purpose: _____

Wife's General Physical Health (please rate yourself)**:**

Very good Good Average Poor Improving Declining

If not very good, please explain.

List all illnesses, allergies, injuries or handicaps that presently affect you.

Medications: Please list any medications you are currently taking.

1. _____ Purpose: _____
2. _____ Purpose: _____
3. _____ Purpose: _____
4. _____ Purpose: _____

SECTION THREE: CHURCH AFFILIATION

1. Are you member(s) of a local church? Yes No (Circle One)
2. If so, what is the name and location of the church? _____
   _____
3. If so, how long have you attended this church? _____
4. Are you actively involved in your church? Yes No (Circle One)
5. Do you have a person/people to whom you are accountable at your church? Yes No (Circle One)
6. Do you believe being an active part of a community of believers is important to reaching your goals in counseling? Why? Why Not?

SECTION FOUR: REFERRAL

Please provide the information below regarding who referred you to Metroplex Counseling. May we send them a card extending our appreciation for their trust in our services?
Yes No (Circle One)

Name:_____ Email:_____
Address: _____ Phone: _____
Church/Ministry Affiliation: _____

SECTION FIVE: Preliminary Assessment

1. **Husband** should place an **"H"** and **wife** should place a **"W"** next to all that apply to you at this time:

____	____ I feel depressed	____ ____	I feel anxious
____	____ I feel insecure	____ ____	I feel inferior
____	____ I feel hopeless	____ ____	I feel fearful
____	____ I feel angry	____ ____	I struggle with anger
____	____ I feel sad	____ ____	I think of suicide
____	____ I feel inadequate	_____	I have obsessive thoughts

____	____ I struggle with compulsive behaviors	____	____ I struggle with lust
____	____ I struggle with worry	____	____ I struggle with doubt
____	____ I struggle with bitterness	____	____ I feel worthless
____	____ I am having marital problems	____	____ I struggle with my in-laws
____	____ I have children	____	____ I struggle as a parent
____	____ I abuse alcohol	_____	I use illegal drugs
____	____ I use prescription drugs	_____	I abuse prescription drugs
____	____ I view pornography	_____	I struggle sexually
____	____ I have committed adultery	_____	My spouse has committed adultery
____	____ My spouse is a poor communicator	_____	I am a poor communicator
____	____ I do not attend church regularly	_____	I do not read my Bible often
____	____ Jesus is important in my life	_____	I don't think about Jesus much
____	____ I strongly fear rejection	_____	I have been sexually abused
____	____ I have been physically abused	_____	I have been verbally abused
____	____ I have been sexually abusive	_____	I have been physically abusive

2. Briefly describe why you have chosen to seek counseling:
Husband:

Wife:

3. What do you hope to achieve throughout the counseling process?
Husband:

Wife:

SECTION SIX: CLIENT RIGHTS AND RESPONSIBILITIES/INFORMED CONSENT

COUNSELOR CREDENTIALS AND LICENSURE: (check the name of your counselor):

___Jeremy Lelek, Ph.D., LPC

___Tim Watson, M.A., LPC

___Matt Sessoms, M.A., LPC,LMFT

___Jonathan Fisher, M.A., LPC

___Kathy Haecker, M.A., LPC

___Sharon Fulcher-Estes, LPC

___Rachel Kuchem, LSMW (Intern)
Supervised by Jeremy Lelek, Ph.D., LPC-S

___Joel Peterson, M.A., LPC-Intern
Supervised by Jeremy Lelek, Ph.D., LPC-s

___Haleigh CeBallos, M.A., LPC-Intern
Supervised by Jeremy Lelek, Ph.D., LPC-S

Your counselor holds either a license or a temporary license in the State of Texas to provide counseling services, or is a student working toward fulfillment of educational requirements necessary for completion of a graduate degree in counseling. Under this license, he or she practices under the authority of the Texas LPC licensing board, and therefore must adhere to the board's ethical guidelines. If you have a complaint regarding the services provided by your counselor, you have the right to file a grievance with the following agency:

Texas State Board of Examiners of Professional Counselors
1100 West 49th Street
Austin, TX 78756
512-834-6658

BOTH HUSBAND AND WIFE MUST READ AND ACKNOWLEDGE:

_____(initial) I understand my counselor's credentials and qualifications/limitations as stated above.

_____(initial) I understand that at any time I can terminate the counseling relationship. If I have a concern or complaint about my counselor, I am free to discuss those concerns with him/her. If my concern is not addressed to my satisfactions, I understand that I can express that concern to the Texas State Board of Examiners of Professional Counselors listed above.

METHOD OF COUNSELING:

_____(initial) I understand that my counselor provides counseling based on biblical principles, that he or she is a Christian counselor believing Jesus Christ as the son of God, who offered life in His name on the basis of belief in His atoning death.

_____(initial) I understand that my counselor will work with me in a manner that, though shaped by and impacted by his or her faith, will help me toward my intended goals, though I may not share that same faith.

GOALS, RISKS, AND BENEFITS:

_____(initial) I understand the goal of the counseling I will receive is to confront personal and interpersonal issues and painful emotions.

_____(initial) I understand the possibility that during the counseling process some emotional and interpersonal symptoms may worsen before they get better.

_____(initial) I understand that other resources will likely be suggested during the counseling process and that these are key to reaching my goals in a timely manner.

LENGTH OF COUNSELING:

_____(initial) I understand that the length of counseling will be a joint effort on my part and that of my counselor, based on the unique strengths and weaknesses I bring to the counseling process, as well as the nature of the problem(s) to be addressed therein.

_____(initial) I understand that the goal of the counseling process is to thoroughly and adequately address my concerns, and to be done so in a timely manner, without unnecessary waste of time and money.

_____(initial) I understand that the length of the counseling process is significantly related to the effort and time I put into it.

FEES:

_____(initial) I understand that counseling sessions will be 50 minutes in durations.

_____(initial) I understand that payment is due when services are rendered.

_____(initial) I understand that Metroplex Counseling does not file insurance claims nor receive insurance payments.

_____(initial) I understand that I will be provided with appropriate documentation in order to self-file with my insurance company.

_____(initial) I understand the selected counselor has the right to withhold further counseling if I do not financially meet the obligation of payment as cited above._____(initial) **I understand the fee structure associated with the selected counselor indicated as below.**

___Jeremy Lelek - $150

___Matt Sessoms - $125

___Kathy Haecker - $120

___Haleigh CeBallos (LPC-Intern) - $100

___Sharon Fulcher-Estes, $130

___Tim Watson - $125

___Jonathan Fisher - $125

___Rachel Kuchem LMSW (Intern) $100

___Joel Peterson, (LPC-Intern) - $100

CANCELLATION POLICY:

_____(initial) I understand my appointment time is reserved exclusively for me and that I will be charged and expected to pay at the full session rate for any and all appointments for which I do not show up or for which I do not provide 24-hour notification of cancellation.

OUR RELATIONSHIP:

_____(initial) I understand that the relationship that I have with my counselor is professional in nature and that personal and social interaction is inappropriate and will be avoided**.**

_____(initial) I understand that my offering of gifts and requests for written references compromises the professional nature of the counseling relationship and should be avoided.

EMAIL AND PHONE CONSULTATIONS

_____(initial) I understand that my counselor does not provide counseling via email and that all email correspondence with my counselor should be kept to a minimum and will not involve the giving of advice or counsel, nor should it be expected to address sensitive issues.

_____(initial) I understand that if required, time spent by my counselor sending or responding to emails or phone conversations when exceeding more than 15 minutes will be billable for a minimum of one half hour with payment due at the next counseling appointment.

STATEMENT OF CONFIDENTIALITY:

Counseling will adhere to very strict confidentiality standards. Client information is managed using procedures designed to protect the privacy and security of personal data. Counseling records are strictly confidential, except as noted below under section entitled Right to Privacy. In order to protect your right to confidentiality, your written authorization is required if you desire that information be shared by us about your counseling to another person or agency.

In the case of marriage or family counseling, there is limited confidentiality, ***meaning that confidentiality belongs to the relationship and not to the individual***. When expedient the counselor will share with the counselee the intent to notify relatives or authorities before the above actions are taken.

Couples Counseling: Due to couples work involving two people, the following information is important for clarification. When we work with couples, the identified "client" is the couple. In order for counseling information to be released, both members of the couples must provide their written authorization. Since the couple is the client, one member's desire to have information released is not sufficient.

Further, information discussed in couples counseling is for counseling purposes and is not intended for use in any legal proceedings involving the partners. By initialing below (Statement of Confidentiality) you are acknowledging our statement of confidentiality regarding couples counseling and agreeing not to subpoena any counselor or employee at Metroplex Counseling to testify for or against either party or to provide records in a court action.

During the course of couples counseling, we generally prefer that the two members of the couple are seen together for sessions, because our professional opinion is that healthy relationships are built on openness and truth. Sometimes in working with couples it may be necessary to see each of you in one or more one-on-one sessions. If individual, one-on-one sessions are indicated, such sessions are to be viewed by the couple as a part of the couple therapy. Toward this end, you agree that anything you share in an individual session may be discussed in subsequent therapy sessions where your partner is present. This does not mean that every issue discussed in an individual session will necessarily be brought up in couples counseling. It simply means that you have given the counselor permission to do so, if it is believed to be important to the health of your relationship.

Our policy of not keeping secrets is designed to help everyone feel safer in counseling. It also allows your counselor to be completely honest, without having to be concerned about who told him or her what or when. If you have any questions about whether a topic is one that needs to be brought up in the joint session, please ask your counselor ***before*** sharing any actual details of your particular situation. If you have reservations about raising a topic, your counselor will be happy to refer you to another counselor for individual counseling in order to give the matter proper attention.

This agreement also applies to phone calls, voice mail messages, and e-mail messages. If you contact your counselor between sessions, he or she will expect you to let your partner know that you have done so. Contents of phone calls, voice mail messages, and e-mail exchanges may be shared. By signing this agreement, you are giving permission to discuss any information shared with your counselor privately with the other person regularly attending counseling with you.

_____(initial) **I have read and do fully understand this statement of confidentiality.**

CLIENT RECORDS AND RELEASE OF INFORMATION:

All communication between the client and counselor becomes part of the clinical record. Records are the property of Metroplex Counseling. In accordance with legal requirements, adult client records may be disposed of five years after the file is closed; minor client records are disposed of seven years after the client's 18th birthday.

In the case of marriage, couples, or family counseling, there is limited confidentiality, ***meaning that confidentiality belongs to the relationship and not to the individual***. Therefore, the clinical record belongs to the relationship, not to the individual.

While most communication between a client and counselor is confidential, the following limitations and expectations do exist:

- **With Written Consent**

A client may request that specific information be sent to another individual. Prior to a disclosure, the client must sign a "Consent for Release of Information". Information will not be released for reasons unrelated to treatment.

In the event that the client is a relationship, rather than an individual, written consent must be obtained by all parties in the relationship prior to release of information.

- **Without Written Consent**

Client information may be released without consent in the following situations:

- Case records may be utilized for purposes of supervision, professional development, and research. In such cases, to preserve confidentiality, clients are identified by first name only.
- The counselor determines if the client is a danger to himself or someone else.
- The client discloses abuse, neglect, or exploitation of a child, the elderly, or a disabled person.
- The client discloses sexual contact with another mental health professional.
- The counselor is ordered by a court to disclose information.
- The counselor is otherwise required by law to disclose information.

_____(initial) **I have read and do fully understand this statement of client records and release of information.**

SUPERVISION:

The staff of Metroplex Counseling operates as a team to improve the quality of counseling we offer. Your counseling may be discussed with your counselor's clinical supervisor, center director, and other counselors at Metroplex Counseling (during group supervision). ***Such discussions will remain confidential***. Names will only be shared with the director or clinical supervisor on an as needed basis. Tape or video recording may be made of your counseling sessions for professional training purposes. This will be done only with your knowledge and permission. Your counselor will discuss this with you.

_____(initial) I understand that my case may be discussed in clinical supervision with the intent of providing better care in my behalf, and that any video or audio recordings would be done so only with my written consent.

REFERRALS:

_____(initial) I understand that should a referral be deemed necessary or requested, my counselor will provide such referral in accordance with his or her professional judgment.

_____(initial) I understand that should my counselor provide for me a referral, it is my responsibility to evaluate and contact those referral alternatives.

EMERGENCIES:

During office hours, the client can contact the counselor at 817-571-4110. If the client is unable to reach his counselor in a timely manner, he/she should contact a physician, a local emergency room or the local police department when necessary and appropriate (dialing 911). It is the client's responsibility to seek the appropriate resources in emergency situations.

_____(initial) **I understand that my counselor does not provide 24-hour emergency crisis counseling. Should I experience an emergency requiring immediate mental health attention, I will immediately access help via a 911 emergency call or go to the emergency room at a local hospital.**

SIGNATURES:

By your signature below, you indicate that you have read and understood this statement, and any questions about this statement were answered to your satisfaction. A copy of this completed form will be provided to you at your request. Your counselor, by indication of his or her signature, verifies the accuracy of this statement and acknowledges his/her commitment to conform to its specifications.

Husband Printed
Signature:_____Name: _____

Date: _____

Wife Printed
Signature:_____Name: _____

Date: _____

Counselor Printed
Signature:_____ Name: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I,_____, **(husband)** have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

I,_____, **(wife)** have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make a new Notice available upon request.

USES & DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

1. We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
    - *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or other practitioner.
    - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within Metroplex Counseling, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of Metroplex Counseling, such as releasing, transferring, or providing access to information about you to other parties.

2. We may disclose to a family member, other relative, a close personal friend of yours, or any other person identified by you, the health information directly relevant to such person's involvement with your care or payment related to your health care.

3. **Contacting You.** We may use and disclose health information to reach you about appointments and other matters. We may contact you by mail, telephone or email. We may leave voice messages at the telephone number you provide us with, and we may respond to your email address.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission that is above and beyond the general consent that permits only specific disclosures. In those instances, when we are asked for information for purposes

outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your counseling notes. *"Counseling notes"* are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or counseling notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Texas Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against us with the State Board of Examiners, the board has the authority to subpoena confidential mental health information from us relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without written authorization from you or your personal or legally appointed representative, 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 we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.
- **Health-Related Services.** We may use and disclose health information about you to send you mailings about health-related products and services available at Metroplex Counseling.

PATIENT RIGHTS

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request. You may revoke the authorization, in writing, at any time, but we cannot take back any uses or disclosures of your health information already made with your authorization.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a paper copy of this Notice at any of our facilities or by calling 817.571.4110. You may view this Notice at our Web site, http://www.metroplexcounseling.com/gettingstarted/intake-form.html.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained inthe

record. We may deny your request. On your request, we 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 (as described previously). On your request, we will discuss with you the details of the accounting process.

CHANGES TO THIS NOTICE

Metroplex Counseling may change this Notice at any time. Any change in the Notice could apply to medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current Notice at each of our facilities and on our Web site, **www.metroplexcounseling.com**. The effective date of the Notice is on the first page in the top right corner.

QUESTIONS OR COMPLAINTS

For more information about our privacy policy or have questions or concerns, please contact us. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may complain to us using the contact information listed at the end of this Notice. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will provide you with that address to file your complaint upon request.

Contact Officer: Jeremy Lelek
Telephone: 817-571-4110
Address: 209 N. Industrial Blvd. #237
Bedford, TX 76021