Reid Counseling Group PLLC
Confidential Client Data

Daniel Reid Johnson MEd. LPC-S

This information is for office admin and to better understand you and your situation.
All information will be held in strict confidence.

Date: _____/_____/_____

Personal Information

Name: _____ Birthdate: ____ /____/____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Sex: ____ M ____ F Marital Status: _____ E-mail: _____

SSN: _____-_____-_____ Referred by: _____

Responsible Party

Name: _____ E-mail: _____

Relationship to client: ___ Self ___ Spouse ___ Child ___Other (please indicate): _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Previous Counseling or Psychotherapy

From whom: _____

Address: _____ City: _____ Zip: _____

Approximate Dates: _____

Focus of therapy?

Credit Card Authorization Form

I authorize REID Counseling Group PLLC to charge this credit card for services rendered by permission, in the case of a missed appointment, or an appointment not canceled at least 24 hours in advance.

I understand it is my responsibility to keep an updated copy of my credit card information on file. If my credit card is declined for any reason, I am responsible for immediate payment of the full balance by cash or check.

_____

Client Signature Date

Name as it appears on card _____

___MasterCard ___VISA ___AMEX Card # _____

CCV _____ Expiration _____ Zip _____

Billing address ***if different from above***.

GENERAL INFORMATION AND PROCEDURES

INFORMED CONSENT / PROFESSIONAL DISCLOSURE

Once again, Welcome to my practice. I look forward to working with you. It is important to me that you feel comfortable and at ease as you enter counseling. The following information should help you to make informed decisions about your therapy. Additionally, the state of Texas requires all Licensed Professional Counselors provide their clients with the following information in the initial session.

Qualifications: Certified as a Licensed Professional Counselor-Supervisor by the Texas State Board of Examiners of Professional Counselors. I am a member of the Christian Association of Psychological Studies, and American Association of Christian Counselors. Founder / owner of Reid Counseling Group. I received my Master of Education Counseling degree from the University of Houston and completed over 3000 hours of supervised counseling/training at The Juliana Poor Counseling Center under the supervision of Adam Mason MAMFC LPC-S.

Experience: I have 16 years experience in a counseling/support role prior to licensing as a Pastor/Ministry Director. My prior to licensure experience has provided the opportunity to counsel/coach couples, individuals, adolescents, families, and groups. This experience allowed me to encounter a variety of hurts and needs to include but not limited to spiritual issues and direction, substance abuse, sexual addiction, depression, anxiety, grief management, and relationship centered issues. I began working as a LPC in 2008 and opened REID Counseling Group PLLC in 2010. If you have any questions concerning my credentials please request a copy of my curriculum vitae.

Nature of Counseling: Individual, couples, adolescents, and group counseling utilizes interpersonal, affective, cognitive-behavioral, and rational emotive methods to achieve mental, emotional, physical, social, moral, and spiritual development through the life span. Additionally, testing and assessment using formal and informal instruments and procedures, for which the counselor has received appropriate training, may be used. During counseling specific goals for growth will be identified, which are mutually agreed upon by both the client and the counselor.

Consultation: In an attempt to gain other perspective and ideas as how to best help you reach your goals, I have regular consultation with other professionals regarding clients with whom I am working. Such consultations are conducted in such a way that complete confidentiality is maintained. No "identifying information" is shared in these consultations.

Fees: The client is responsible for payment of fees. Payment is due at the time service is rendered. We do not accept insurance at this time. You may choose to file for out of network benefits and can be reimbursed by your insurance company. We can provide an itemized statement at any time for you. Sessions are **$130.00** and last for 50 minutes. The first 15 minutes of phone consultations are free (does not apply to regularly scheduled phone conversations). After 15 minutes the regular fees apply and are prorated as necessary. Electronic mail consultation fees apply as above. A separate fee will be charged for tests, reports, or expert testimony. A **Late Cancellation fee of $75** will be charged if **less than 24 hours** notice is given. Additionally, if you have a **standing appointment** (a set recurring appointment) weekly and you cancel or fail to attend, unless you call and give notice you will be charged for the upcoming appointment. A credit card number may be required on file to cover these fees.

Counseling Relationship: To get the most out of counseling or therapy, it is important to assume responsibility for your experience. Therapists can only work with the information you provide. Consistent participation in treatment sessions, as well as any "homework" assignments, will facilitate growth in the process. While benefits are expected from counseling, specific results are not guaranteed. Because of the nature of the therapeutic process, you may experience periods of emotional discomfort on the way to your goals. No single therapist is the best for every client. If you do not feel I am the right fit for you, I will be happy to provide referrals for other therapists in the area. You are free to discontinue treatment at any time.

It is my practice to set and maintain professional boundaries. Dual relationship with clients is prohibited. A dual relationship is any non-counseling activity initiated by either the licensee or the client for the purpose of establishing a non-therapeutic relationship. Furthermore, sexual intimacy with clients is never appropriate and should be reported immediately.

Client Rights and Responsibilities: Some clients need only a few counseling sessions to achieve their goals; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might be harmful. You agree to come to counseling free from the influences of drugs including alcohol. I also have the right to terminate our counseling relationship if I believe it is in your best interest.

I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may refer your complaints to the Texas Board of Examiners of Professional Counselors at: 1100 West 49th Street, Austin, TX 78756-3183, telephone (512) 834-6658 for any questions, comments, or complaints.

Referrals: When it is appropriate I will terminate a professional counseling relationship if it becomes reasonably clear that you are not benefiting from the relationship. When professional counseling is still indicated, I will take reasonable steps to provide referrals and/or alternatives that may be available to help you. You will be responsible for contacting and evaluating those referrals and/or alternatives. Clients may obtain a second opinion from another mental health professional and/or may discontinue therapy at any time.

Records and Confidentiality: You are protected according to federal law (Regulation 42 CFT Part 2). Also, in 22 Texas Administrative Code, Chapter 681, Section 681.36 (a) provides that communications between a licensee and client, and client's records, however created or stored, are confidential under the provisions of the Health and Safety Code, Chapter 611. Section 611.002 (a) provides that communication between a patient and a professional, are **confidential**. One of my highest priorities is protecting your confidentiality in all matters within the scope of the law. However, there are some limits to confidentiality. Here are a few of those exceptions: a) Under court orders I can be forced to relinquish records for judicial matters; b) Situations in which you are potentially suicidal; c) In instances where there is child abuse, neglect of minors or elder abuse; d) Circumstances where you try to harm or threat to harm another individual; e) Information may be provided to parents, especially if client is a minor.

There are other exceptions as well that are not listed. If you ever have any questions about any issue of confidentiality, please request a clarification. As we work together, any exceptions to confidentiality will be identified as they arise.

Other Privacy issues: Recent laws have been enacted for client privacy. It is important to know that emails, text, and mobile phone conversations are not secure and guaranteed of privacy because they can be potentially intercepted. Therefore, by signing this document you understand that if we have correspondence by email, text, or mobile phone, there is a potential for confidentiality to be compromised.

Emergency Contact: In the event of an emergency call 911 or have someone take you to the emergency room for evaluation. For after business hours contact, call the main number 281-968-9119. Please leave a message and the nature of your call and I will make every effort to return your call the next morning. There may be times when another clinician will be on call for me and will be handling all client calls.

Acknowledgment and Consent: By your signature below, you are indicating that you read and understood this statement, or that any questions you had about this statement were answered to your satisfaction, and that you were furnished a copy of this statement. By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

_____ _____

Client's Signature Counselor's Signature

_____ _____

Date Date

Current Concerns:
What concern brings you in?

When did this concern begin (give dates)?

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern:

What do you hope to accomplish in counseling?

What kind of obstacles could get in the way?

Where do you see yourself in 6 months?

Behavior – circle any of the following behaviors that apply to you:

Overeat	Suicidal attempts	Can't keep a job	Take drugs	Compulsions
Insomnia	Vomiting	Smoke	Take too many risks	Odd behavior
Withdrawal	Lack of motivation	Drink too much	Nervous tics	Eating problems
Work too hard	Procrastination	Sleep disturbance	Crying	Impulsive reactions
Phobic avoidance	Outbursts of temper	Loss of control	Aggressive behavior	Concentration difficulties

Are there any specific behaviors, actions, habits that you would like to change?

Feelings – circle any of the following feelings that apply to you:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Others:	

Physical – circle any of the following symptoms that apply to you:

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Dry mouth	Palpitations	Fatigue	Burning or itchy skin	Muscle spasms
Twitches	Chest pains	Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling	Watery eyes
Visual disturbances	Numbness	Flushes	Hearing problems	Don't like being touched

Biological Factors:

Do you have any current concerns about your physical health? Please specify:

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):

Do you get regular exercise? If so, what type and how often?

Check any of the following that apply to you:

	Never	Rarely	Frequently	Very Often		Never	Rarely	Frequently	Very Often
Marijuana					Heart problems				
Tranquilizers					Nausea				
Sedatives					Vomiting				
Aspirin					Insomnia				
Cocaine					Headaches				
Painkillers					Backaches				
Alcohol					Early morning awakening				
Coffee					Fitful sleep				
Cigarettes					Binge / Purge				
Narcotics					Poor appetite				
Stimulants					Eat “junk foods”				
Hallucinogens					Lack of interest in activities				
Diarrhea					Constipation				
Compulsive Exercise					High blood pressure				
Use Laxatives					Allergies				

Spiritual Interests/Assessment

Do you have a specific set of beliefs or values that make up your present worldview? yes no

Do you consider yourself to be a spiritual or religious person? yes no

Are you affiliated with any specific religious tradition?

If yes, how important are those beliefs, values, and principles in your everyday life?

*Is there anything else that you would like for us to know about you right now, that we have not asked for or covered in this initial assessment? (Use back page if needed)