



Brazos Valley Christian Counseling

New Client Information Packet

Thank you for choosing **Brazos Valley Christian Counseling** for your counseling needs. The following pages contain:

- Professional Disclosure Statement
- Informed Consent Form
- Notice of Privacy Practices
- Background Information Form

Please complete each of the attached pages and bring them with you to your first appointment.

If you have any questions prior to your appointment, please feel free to call us at 979.260.6700 or email your counselor at NoelANeely.LPC@gmail.com

Again, thank you for choosing **Brazos Valley Christian Counseling**. We look forward to meeting with you soon.



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Professional Disclosure Statement

Noel A. Neely, M.S., LPC

Qualifications & Experience: Noel received her master of science degree in counseling from Southern Methodist University in 2011 and earned her bachelor of science degree in sociology from Texas A&M University in 2008. She is licensed in the state of Texas as a Licensed Professional Counselor (LPC) and has received training in working with women struggling with perinatal mood disorders including postpartum depression and anxiety. Noel has a heart for working with women and moms struggling with anxiety, depression, grief and loss, stress management, infertility, miscarriage, postpartum struggles, self-esteem issues, anger management, and life adjustments.

Nature of Counseling: Counseling is an opportunity for you to work individually, in a group, as a couple, or as a family on specific issues concerning you in a safe, non-judgmental environment. The counselor-client relationship is a collaborative one that is based upon cooperation, mutual trust, respect, and alignment of goals. I trust that the counselor-client relationship will provide a caring environment in which you will be assisted in reaching your goals for personal growth. Together we will attempt to resolve your concerns using a variety of strategies including processing your thoughts and feelings, learning and applying cognitive behavioral skills, and being continually encouraged throughout the process.

Informed Consent

**Please initial next to each section after you have read and understood the section and any questions you had about the section were answered to your satisfaction.*

_____ **Emergency/Crisis:** Please know that we do not provide a 24-hour crisis counseling service. Should you experience an emergency necessitating immediate mental health attention, immediately call 9-1-1 or go to the nearest emergency room for assistance.

***Please note that this includes both emails and phone messages. Please do not email in the case of crisis or emergency.**

_____ **Assessments:** Brazos Valley Christian Counseling does offer psychological assessments in order to (1) to help clarify or identify the problem areas more comprehensively for you and your counselor and (2) to use the assessments as a direct way of ascertaining an additional measure of therapeutic progress. Before an assessment is administered, your permission and understanding of the purpose of the assessment will be ascertained. Furthermore, all assessment results will be reviewed with you.

_____ **Counseling Relationship:** During the time we work together, we will meet for approximately 50 minutes per session. Although our session may be very intimate psychologically, we have a professional



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relationship rather than a social one. Please do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling sessions. You will best be served if our sessions concentrate exclusively on you (adult counseling situations) or your child's concerns (parent consultations for child or adolescent counseling).

_____ **Effects of Counseling:** At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a process of personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

_____ **Client Rights:** If a divorce or a separation of parents has occurred, a current copy of the relevant court documents is required for a second session. If joint custody exists, the parent not bringing the child will also be contacted via letter with an intake form and an invitation to that parent to call with any questions and to participate in their child's counseling---It is Brazos Valley Christian Counseling's policy to involve both parents (unless parental rights have been restricted by a court order) in the treatment process.

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 it is requested 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.

I assure you that my counseling services will be rendered in a professional manner consistent with the current ethical practices promulgated by the Ethical Codes of the Texas State Board of Examiners of Licensed Professional Counselors and the HIPAA security and privacy rules. If at any time for any reason you are dissatisfied with my services, please let me know so that existing issues can be worked through.

_____ **Referrals:** Should you and/or I believe that a referral is needed; I will do my best to provide some alternatives, including programs and/or people who may be available to assist you. You will be responsible for contacting and evaluating those referrals and/or alternatives.

_____ **Fees:** The cost per session is \$90.00 and payment may be made by cash, check or credit card. The fee for each session is due prior to the commencement of the session. All returned checks will incur a \$30.00 return-check fee.

_____ I hereby accept financial responsibility for all therapy sessions, diagnostics, testing, letters, reports, conferences, phone calls, and crisis intervention initiated by me or initiated in my behalf.



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_____ **Cancellation:** In the event that you will not be able to keep an appointment, please give notification within 24 hours in advance. Unless cancelled at least 24 hours in advance, our policy is to charge for missed/cancelled appointments at the rate of \$30.00. Please help us serve you better by keeping scheduled appointments.

_____ **Records and Confidentiality:** All of our communications become part of the clinical record. Records are the property of Brazos Valley Christian Counseling. Adult client records are disposed of six years after the file is closed. Guardians or conservators do have access to child-client files and will need to sign for consent of services (within joint custody cases, only one guardian or conservator is needed to sign for consent for the child). Minor client records are disposed of six years after the client's 18th birthday.

Most of our communication is confidential, but the following limitations and exceptions do exist:

- a. if you are a danger to yourself or someone else;
- b. if you disclose sexual contact with a mental health professional;
- c. if I am ordered by a court to disclose information;
- d. if you direct me to release your records;
- e. if I am otherwise required by law to disclose information;
- f. if there is a reason to believe that abuse or neglect of a child, elderly or disabled person has occurred or is likely to occur.

Should you request a copy of your counseling records, please be aware that a \$30.00 record preparation fee will be incurred and a "Release of Records" form must be signed. An overall counseling summary, in lieu of records, may be requested for a fee of \$30.00 as well. If records are subpoenaed, this does not indicate an automatic release of records and we may choose to seek a court order quashing the subpoena or providing protection should disclosure be deemed not in the client's best interest.

To further protect your confidentiality, if I see you in public, I will only acknowledge you if you approach me first. In the case of marriage or family counseling, I will keep confidential (within limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members, and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to the therapeutic process.

_____ **Consultation:** I give my consent for the counselor involved in my case to consult with other staff at Brazos Valley Christian Counseling regarding my case to assist in treatment planning and service delivery. I understand that any consultation will be done in a confidential manner and not provide any information regarding my identity.

_____ **Confidentiality for Minors (if applicable)**

_____ I agree to grant confidentiality for minor unless there is a probability of imminent danger to the



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child.
_____ I do not agree to grant minor confidentiality.

Name of Child

Date

_____ **Court appearances:** If Noel Neely is compelled to appear or testify on your behalf, either in a deposition or in court, you agree to pay her for her time out of the office. The associated cost will be \$250.00 for up to 60 minutes of her time, with an additional \$150.00 charged for every hour (or partial hour) thereafter. Billable time will include the average drive time to and from Brazos Valley Christian Counseling and the place of testimony.

_____ **Court/Insurance/or Attorney documents:** Noel Neely charges \$200.00 per hour to complete requested or subpoenaed documentation on your behalf. There is no charge for providing you with a standard receipt needed for insurance reimbursement purposes.

By your signature below, you are indicating that you have read and understood this document, or that any questions you had about this document were answered to your satisfaction. You acknowledge your commitment to comply with all of its terms and requirements and acknowledge understanding and agreement with the financial obligations.

Client's Signature (over the age of 12)

Date

Guardian's Signature

Date

Counselor

Date



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Informed Consent

Brazos Valley Christian Counseling holds your confidentiality in the highest regard, from your identity to the information you offer in session. All client information is protected under both state and federal confidentiality laws. Specific information pertaining to your case will not be released to anyone except as allowed by law. This office may disclose confidential information only:

1. If there is evidence or reason to believe that a situation of abuse and/or neglect of a child, elderly or handicapped person exists. By law, this information must be reported to the Texas Department of Protective and Regulatory Services or the police.
2. If client discloses sexual contact with a mental health professional.
3. To a government agency if the disclosure is required by law.
4. To a medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others; or there is a probability of immediate mental or emotional injury to the patient.
5. To qualified personnel for management/financial audits, program evaluations or research step.
6. To a person who has the written consent of the patient, or a parent if the patient is a minor, or a guardian if the patient has been adjudicated as incompetent to manage the patient's personal affairs.
7. To the patient's personal representative if the patient is deceased.
8. To individuals, corporations, or governmental agencies involved in paying or collecting fees for a mental or emotional health services provided by a professional.
9. To health care personnel of a penal or other custodial institution in which the patient is detained if the disclosure is for the sole purpose of providing health care to the patient.
10. A court order may involve providing the court and litigants with verbal testimony and/or records such as clinical notes, tapes, letters, testing, and ledgers.

I do hereby give my (our) consent for counseling and/or related services at this facility. I (we) understand that all information pertaining to my (our) services all remain completely confidential except in those cases where confidentiality is limited. These limits of confidentiality, as prescribed by state and federal law, have been explained to me. I further understand that any release of information concerning my (our) services shall occur only with my written consent, excluding the above stipulated exceptions.

Client Signature: _____ Date: _____

I affirm that I am the legal conservator/guardian of _____ and hereby grant permission for my child to participate in counseling services at Brazos Valley Christian Counseling. If there is shared custody, I will provide this therapist with a copy of the most recent divorce decree on custody order and know that the other conservator/guardian can also have access to my child's records.

Guardian Signature: _____ Date: _____



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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by The Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by **Brazos Valley Christian Counseling**, and of your individual rights and **Brazos Valley Christian Counseling's** legal duties with respect to confidential information.

Ways in Which We May Use and Disclose Your Protected Health Information

We may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing mental health care and related services. *For example* – use or disclosure by the health care provider in training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.
- **Payment** means activities such as obtaining payment for the mental health care services we provide for you either from your insurance or another third party payer. *For example* – we may include information with a bill to a third party payer that identifies you, your diagnosis, and procedures performed.
- **Health care operations** include the business aspects of running our practice. *For example* – to evaluate our treatment and services, or to evaluate our staff's performance while caring for you.

We may contact you to provide appointment reminders or other services that may be of interest to you. We will disclose your protected health information to any person *you identify* that is involved in your care or payment for your care. *For example* – a family member, relative, or close friend with whom you have asked us to communicate.

We will use and disclose your protected health information *when required by federal, state, or local law*. There are certain situations in which as a therapist I am required by ethical standards to reveal information obtained during therapy to other persons or agencies – even if you do not give permission. These situations are as follows: (a) if you are a danger to yourself or someone else; (b) if you disclose sexual contact with a mental health professional; (c) if I am ordered by a court to disclose information; (d) if you direct me to release your records; (e) if I am otherwise required by law to disclose information; (f) if there is a reason to believe that abuse or neglect of a child, elderly or disabled person has occurred or is likely to occur.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke an authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. Please sign to indicate you understand our operational use of your information for treatment, payment, and health care operations as stated above.

Signature of Client

Date



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Adult Background Information Form

Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed.

Name: _____ Date of First Visit: _____
Last First MI

Home Phone: _____ (May call: Yes No Message: Yes No)

Work Phone: _____ (May call: Yes No Message: Yes No)

Cell Phone: _____ (May call: Yes No Message: Yes No)

Email Address: _____

Home Address: _____
Street City State Zip

Best time to contact you: _____ Occupation: _____

In case of emergency, I authorize Brazos Valley Christian Counseling to contact:

Name: Last, First Relationship Phone

Gender: Male ___ Female ___ Date of Birth _____ Age _____

Ethnicity:
African American ___ Bi-racial ___ Hispanic/Latino ___
Asian ___ Caucasian ___ Native American ___ Other _____

Are you currently in counseling elsewhere? Yes No

Are you seeking services because you are a victim of a crime? Yes No

Did it result in legal action? Yes No Are you currently on probation? Yes No

Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No
(If so, we may need your permission in order to communicate with that individual or agency).

Previous Mental Health Professional/Agency _____

Phone _____ Dates of Service _____ (beginning-ending)

Have you ever been hospitalized for mental health concerns? Yes No

If yes, please explain: _____



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How were you referred to Brazos Valley Christian Counseling? _____

Educational Level:

8th grade or below _____ Trade School _____ Master's Degree _____
High school _____ Some College _____ Ph.D. Degree _____
GED _____ College Graduate _____

Marital Status (indicate all that apply and duration of each, ex. 1960-1980):

Never Married _____ Separated 1 _____ Divorced 1 _____ Widowed 1 _____
Married 1 _____ Separated 2 _____ Divorced 2 _____ Widowed 2 _____
Married 2 _____ Separated 3 _____ Divorced 3 _____ Widowed 3 _____
Married 3 _____

If divorced, circle the number which best describes your relationship with your ex-spouse.

1 _____ 2 _____ 3 _____ 4 _____ 5 _____
Hostile Frustrating Friendly

Are you currently involved in a custody dispute? Yes No (If yes, please explain) _____

Current Living Arrangements:

Family of Origin _____ Relatives _____ Single _____
Married _____ Roommate(s) _____ Single parent with children _____
Married with children _____ Significant other _____ Other _____

Present Family

If married with children, list your family, beginning with the oldest member and include yourself.

Name	Age	Gender	Relationship to you (include step, half, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family of Origin Primary Household (Family in which you resided the majority of your life)

List your family members, by household, beginning with the oldest member (include parents & self):

Name	Age	Gender	Relationship to you (include step, half, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



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Family of Origin Second Household (If Applicable)

Name	Age	Gender	Relationship to you (include step, half, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mother's Marital Status (indicate all that apply and duration of each, ex. 1960-1980):

Married _____ Remarried _____ Divorced _____
 Separated _____ Widowed _____ Unknown _____
 Number of Marriages _____

Father's Marital Status (indicate all that apply and duration of each, ex. 1960-1980):

Married _____ Remarried _____ Divorced _____
 Separated _____ Widowed _____ Unknown _____
 Number of Marriages _____

HEALTH SECTION

Primary Care Physician: _____
Name

Address _____ Phone _____

Psychiatrist: _____
Name

Address _____ Phone _____

Physical Disability: Yes No (if yes, please explain) _____

Chronic Illness: Yes No (if yes, please explain) _____

Terminal Illness: Yes No (if yes, please explain) _____

Check the following items for a diagnosis or medication you are now receiving or have received:

Diagnosis	Current	Past	Date of Diagnosis	Name of Medications	Dosage
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
ADD	_____	_____	_____	_____	_____



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Learning Disability	_____	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____	_____
Panic Attack	_____	_____	_____	_____	_____
Manic-Depression (Bipolar)	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia	_____	_____	_____	_____	_____
Obsessive/Compulsive	_____	_____	_____	_____	_____
Addictions	_____	_____	_____	_____	_____
Convulsions	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication, please bring the medication to your next session).

If you have been diagnosed, who have the diagnosis?

Counselor/Psychologist _____ Family Physician _____ Psychiatrist _____ School _____ Other _____
Name: _____ Phone: _____

List other medications you are currently taking:

Med. _____ Dosage _____
Med. _____ Dosage _____
Med. _____ Dosage _____

CURRENT CONCERNS

Indicate severity of up to 10 items (1-mild; 2-moderate; 3-severe) Circle the item that you see as the MOST significant issue).

- _____ Abuse (physical, emotional, sexual)
- _____ Adjustment to life changes (changing schools, parents divorcing, moving, getting married or divorced, aging, etc)



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- _____ Career dissatisfaction or decisions
- _____ Disturbing memories (past abuse, neglect or other traumatic experiences)
- _____ Drug or alcohol use (both legal and illegal drugs)
- _____ Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
- _____ Family or Step-family relationship
- _____ Feeling angry or irritable
- _____ Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc)
- _____ Feeling guilty or shameful
- _____ Feeling sadness or depression or suicidal urges NOT related to grief
- _____ Feeling sadness or depression or suicidal urges related to grief
- _____ Health concerns (physical complaints and/or medical problems)
- _____ Illegal behaviors (repeated run-ins with the law, etc)
- _____ Learning/Academic difficulties
- _____ Non-family relationship (roommates, friends, co-worker, boss, teacher, etc)
- _____ Parent-Child relationship (discipline, adoption, single parent, etc)
- _____ Personal growth (no specific problem)
- _____ Religious or spiritual concerns
- _____ Sexual functioning concerns
- _____ Sexual identity concern
- _____ Significant other/Spouse relationship
- _____ Sleep problem (nightmares, sleeping too much or too little, etc)
- _____ Speech problem (not talking, stuttering, etc)
- _____ Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc)
- _____ Unusual experiences (loss of periods of time, sensing unreal things, etc)
- _____ Other (explain _____)

***Remember to circle the MOST significant issue.**

When did you first become concerned about this issue? _____

How have you attempted before now to deal with this issue? _____

Other treatment you have received to address any of the concerns indicated above: None _____
 Couples Counseling _____ Group Counseling _____ Individual Counseling _____
 Family Counseling _____ Hospitalization _____ Other _____

FAMILY HISTORY/EXPERIENCES

(For each of the following items that apply, write in your approximate age at the time it occurred):

Raised by:

Adoptive parent(s) _____ Institution _____ Relatives _____
 Foster parents _____ Natural parents _____ Single natural parent _____
 Grandparents _____ Natural and step-parent _____ Other _____

Stressors in the Family:

Chronic illness of family member _____ Death of significant person _____ Domestic Violence _____



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Family member absent (explain) _____
Family member's disability/major accident/illness _____
Family member emotional problems (explain) _____
Family member suicide (explain) _____
Financial problems _____ Moved a lot _____ Parents arguing frequently _____ Parents divorced _____
Other _____

History of learning, emotional, behavioral problems: Yes No
(If yes, please explain) _____

History of alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes, please explain) _____

History of criminal activity: Yes No
(If yes, please explain) _____

History of Protective orders: Yes No
(If yes, please explain) _____

Abused (check all that apply): Physically _____ Emotionally _____ Sexually _____
Neglected (check all that apply): Physically _____ Emotionally _____

School Problems (check all that apply):
Academic problems _____ Discipline problems _____ Severely teased _____ Unpopular _____
Other _____

Early Language/Speech Problems (explain): _____

Emotional Concerns (check all that apply):
Appetite change _____ Heard voices _____ Suicidal thoughts _____
Emotional problems _____ Loss of energy or fatigue _____ Suicidal attempts _____ Gained
weight _____ Lost weight _____ Other _____

Behavior Problems (check all that apply):
Accident-prone _____ Aggressive behavior (explain) _____
Alcohol/drug use _____ Attention problems _____ Frequent arguments _____
Hyperactive _____ Impulsive _____ Loner _____
Misbehaved a lot _____ Ran away _____ Taken advantage of _____
Temper outbursts _____ Trouble with the law _____ Other _____

Anxiety Symptoms (check all that apply):
Irritable _____ Obsessive worrying _____ Physical symptoms _____
Keyed up, on edge _____ Phobias _____



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Health/Physical Problems (check all that apply):

Asthma _____ Disability _____ Nervous stomach _____
Bedwetting _____ Dizziness _____ Neurological problems/exam _____
Bone/joint/muscle _____ Headache _____ PMS _____
Chest pain _____ Heart palpitations _____ Serious overeating/undereating _____
Chronic illness _____ Hospitalization _____ Shortness of breath without exertion _____
Developmental delay(s) _____ Major accident _____ Sleep problem _____
Diarrhea _____ Major illness _____ Surgeries _____ Other _____

Dissociative Symptoms (check all that apply):

Amnesia of large parts of childhood after age 5 _____ Things of yours that are missing _____
Memories suddenly flashback _____ Trance-like episodes/lost track of time _____
Things appear but you do not know origin _____ Walk in sleep _____

Trauma/Stressor (check all that apply):

Child separated from parent (how long and when) _____
Death of a pet _____ Death of a significant person _____ Incarcerated family member _____
Medical _____ Natural disaster _____ Sexual Assault _____
Victim of trauma (unusual, terrifying experience) _____ Other _____

Interpersonal Problems (check all that apply):

Aggressive behavior (explain) _____
Bullied _____ Taken advantage of _____ Frequent arguments _____ Temper
outbursts _____ Loner _____ Other _____

Specific to Adulthood (check all that apply):

Abortion _____
Changes in the last 12 months (getting married, becoming a parent, moves, change in employment) _____
Parenting/Discipline problems _____ Placing child for adoption _____ Sexual problem _____

I agree that the above information is accurate to the best of my ability. I also understand that if I have any questions regarding the above questions, I can ask my counselor at any time.

Client/Guardian & Date