

# Interactive

## Counseling & Consulting Services Inc.

216 Market Avenue, Suite 110, Boerne, Texas 78006  
(830) 249-8521

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please give the names, sex, age, and occupation of the other family members with you.**

<u>Relationship</u>	<u>Name</u>	<u>Sex</u>	<u>Date of Birth</u>	<u>Occupation</u>
<u>spouse</u>	_____	_____	_____	_____
<u>child</u>	_____	_____	_____	** legal guardian Y / N
<u>child</u>	_____	_____	_____	** legal guardian Y / N
<u>child</u>	_____	_____	_____	** legal guardian Y / N
<u>child</u>	_____	_____	_____	** legal guardian Y / N
<u>other</u>	_____	_____	_____	_____

\*\* If there are children listed above, please circle YES (Y) or NO (N) if you are the legal parent, legal guardian, managing conservator, or person designated by the court to have the authority to consent to psychological services.

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**May I mail you at this address? \_\_\_\_ YES \_\_\_\_ NO**

Home Phone: (\_\_\_\_) \_\_\_\_\_ BEST TIME TO CALL: \_\_\_\_\_

**May I contact you or leave messages at this phone number? \_\_\_\_ YES \_\_\_\_ NO**

Cell Phone: (\_\_\_\_) \_\_\_\_\_ BEST TIME TO CALL: \_\_\_\_\_

**May I contact you or leave messages at this phone number? \_\_\_\_ YES \_\_\_\_ NO**

**May I TEXT MESSAGE your cell phone for appointment reminders? \_\_\_\_ YES \_\_\_\_ NO**

If yes, please fill in your cell phone provider \_\_\_\_\_

**Work Phone:** (\_\_\_\_) \_\_\_\_\_

**Email Address:** \_\_\_\_\_

BEST TIME TO CALL: \_\_\_\_\_

May I email you? \_\_\_\_ YES \_\_\_\_ NO

May I call you at this phone number? \_ YES \_\_\_\_ NO

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Member ID: \_\_\_\_\_

*Often, behavioral health coverage is managed by another company and may have differing benefits than your medical policy.*

How were you referred to our office? \_\_\_\_\_

May we thank them for your referral today? \_\_\_\_ YES \_\_\_\_ NO

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### Medical History:

Name and city location of Physician \_\_\_\_\_ Date of your last physical exam: \_\_\_\_\_

What symptoms contributed to you coming in today? (Please check all that apply)

- |                                                        |                                                    |                                                   |                                                 |
|--------------------------------------------------------|----------------------------------------------------|---------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> overeating                    | <input type="checkbox"/> restless                  | <input type="checkbox"/> rapid heart rate         | <input type="checkbox"/> compulsive behaviors   |
| <input type="checkbox"/> taking drugs                  | <input type="checkbox"/> depressed mood            | <input type="checkbox"/> sweating                 | <input type="checkbox"/> impulsive behaviors    |
| <input type="checkbox"/> odd behavior/thoughts         | <input type="checkbox"/> crying                    | <input type="checkbox"/> trembling or shaking     | <input type="checkbox"/> fears/phobias          |
| <input type="checkbox"/> recent weight gain            | <input type="checkbox"/> difficulty concentrating  | <input type="checkbox"/> shortness of breath      | <input type="checkbox"/> anxiety                |
| <input type="checkbox"/> recent weight loss            | <input type="checkbox"/> low motivation            | <input type="checkbox"/> muscle tension           | <input type="checkbox"/> vomiting               |
| <input type="checkbox"/> recent appetite changes       | <input type="checkbox"/> aggressive behavior       | <input type="checkbox"/> outbursts of temper      | <input type="checkbox"/> distrust               |
| <input type="checkbox"/> social withdrawal             | <input type="checkbox"/> feelings of worthlessness | <input type="checkbox"/> nightmares               | <input type="checkbox"/> jumpy                  |
| <input type="checkbox"/> family emotional problems     | <input type="checkbox"/> stomach problems          | <input type="checkbox"/> easily distracted        | <input type="checkbox"/> dizzy or lightheaded   |
| <input type="checkbox"/> chest pain                    | <input type="checkbox"/> sleeping too much         | <input type="checkbox"/> decreased need for sleep | <input type="checkbox"/> fatigue/loss of energy |
| <input type="checkbox"/> difficulty falling asleep     | <input type="checkbox"/> problems with school      | <input type="checkbox"/> housing problems         | <input type="checkbox"/> obsessions             |
| <input type="checkbox"/> difficulty staying asleep     | <input type="checkbox"/> pain                      | <input type="checkbox"/> drinking alcohol         | <input type="checkbox"/> relationship problems  |
| <input type="checkbox"/> experienced a traumatic event | <input type="checkbox"/> financial problems        | <input type="checkbox"/> can't turn my mind off   | <input type="checkbox"/> other: _____           |

How do you rate your overall health? Major Problems / Minor problems / Satisfactory / Very satisfactory

Have you ever experienced: (Please mark all that apply)

Emotional abuse \_\_\_\_\_ Physical abuse \_\_\_\_\_ Sexual abuse \_\_\_\_\_ Sexual assault \_\_\_\_\_ Head Trauma \_\_\_\_\_

Do you have any physical, emotional, or mental conditions now or in the past that we need to be aware of? Yes No

If yes, please list: \_\_\_\_\_

Have any members of your family had problems with:

drugs \_\_\_ alcohol \_\_\_ depression \_\_\_ anxiety \_\_\_ other mental illness \_\_\_ diabetes \_\_\_ epilepsy \_\_\_

Any medical conditions within the last 2 years?

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Current medications, vitamins, supplements, or dietary restrictions?

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Do you use alcohol or drugs to (check all that apply): Manage stress? \_\_\_ To relax? \_\_\_ To change mood? \_\_\_ For sleep? \_\_\_

How many hours a night do you sleep? \_\_\_\_\_ If you have difficulty with sleep, circle all that apply:

Falling Asleep / Staying Asleep / Waking & Unable To Fall Back To Sleep / Sleeping Too Much / Nightmares

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### **Social Intake:**

Marital status? \_\_\_\_\_ Previous marriages? Yourself - Yes / No Your spouse - Yes / No

Describe your relationship with your current spouse. (*Circle one*)

Major Problems / Minor problems / Satisfactory / Very satisfactory

Religious Affiliation: \_\_\_\_\_

Religious Service Attendance: Weekly / Monthly / Occasionally / Seldom / Never

Whom do you count on for support (friends, family, co-workers, or others)? \_\_\_\_\_

Please tell us what you want to work on or change in counseling: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long has this been a significant problem for you? *Please be specific (i.e., not "all my life")*. \_\_\_\_\_

Have you had counseling in the past? Yes / No      If yes, was it a positive experience? Yes / No

How will you know when your life is better? \_\_\_\_\_

\_\_\_\_\_

How would you like to proceed? (*Circle one*)

Come frequently now to fix this quick

Come weekly	Come every other week	Come monthly
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I might be here for awhile and looking long term care

Other Notes:

### **Hours of Operation/Emergencies**

ICCS hours of operation vary Monday through Friday. ICCS invites you to discuss your particular scheduling needs with its employees. We do not handle medical emergencies. If you or your family has a crisis, you should call Crisis Resolution & Intake (210-225-5481), the United Way Helpline (210-227-4357), the Emergency Room of University Hospital (210-358-2133), MHMR Crisis Hotline (877-466-0660), Boerne Methodist Hospital (830-331-3000), or phone Emergency (911).

  
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**INFORMED CONSENT & CONTRACT FOR SERVICES**

I, \_\_\_\_\_ request Interactive Counseling & Consulting Services Inc. (ICCS) to provide counseling services for myself to achieve the goals I will set with my therapist.

**Informed Consent**

I understand a licensed professional will provide the counseling services for each session. ICCS staff may review the sessions if necessary. I understand that ICCS staff may contact myself after terminating counseling services. ICCS and its employees do not prescribe medication. If medical treatment is necessary, referrals to qualified physicians will be given. ICCS staff may review the sessions if necessary.

**Benefits/Risks of Counseling**

One major benefit that may be gained from participating in counseling is the resolution of the concerns brought to counseling. Other possible benefits may be a better ability to cope with marital, family, and other interpersonal relationships, and/or a greater understanding of personal goals and values. You may experience discomfort, such as anger, depression, or frustration during therapy as you address counseling issues. Seeking to resolve concerns between family members, marital partner, and other persons can similarly lead to discomfort as well as relationship changes that may not have been originally intended. The greatest risk of counseling is that it may not, by itself, resolve your concerns. We consistently assess your treatment for appropriate progress. If a situation fails to improve or if a situation deteriorates, we will provide referrals to other professionals for consultation or treatment.

**Confidentiality**

ICCS values the privacy of clients and acts accordingly. ICCS follows or exceeds HIPAA standards and procedures for confidentiality. All information shared in this treatment is confidential except in circumstances governed by law. The licensed professional is obligated by law or professional ethics to report incidents of threat to self, threat to others, child abuse/neglect, elderly or dependent adult abuse/neglect, or client abuse by another therapist or doctor. In the event a litigation case is filed that concerns your clinical file, your records may be subpoenaed and we may be obligated to honor these subpoenas. ICCS does not share your personal information with any other agency or business without your written consent, unless your balance due is uncollectable. If you would like me to confer with another healthcare professional, you will need to sign a "Request for Professional Communication" form.

**Financial Agreement**

I agree to pay all charges in full according to the ICCS Financial Agreement for all services at the time of each session. Fees are subject to change every six months. Fees will be charged for any additional professional services rendered at your request or at the request of your therapist, such as phone contacts over 5 minutes, emails, consults with other professionals, etc. Preparation of special forms, reports, court time, etc. will also be charged.

**NO- SHOW AND CANCELLATION POLICY**

Your visit has been reserved for you. 24 hours notice is required for cancellation or you will be personally charged a fee of **\$35.00 for late cancellations. There is a fee of \$50.00 for NO SHOWS.**

**Services to Children**

I verify that I am the legal parent, legal guardian, managing conservator, or a person designated by the court to have the authority to consent to provide psychological services for the child(ren) listed below. I represent that I am authorized to grant this consent for professional services and request that ICCS provide clinical services for the child(ren). [Please PRINT]

\_\_\_\_\_  
Child's Name (First & Last)

\_\_\_\_\_  
Child's Name (First & Last)

\_\_\_\_\_  
Child's Name (First & Last)

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**I have read, agree, understand, and have been advised by my licensed professional concerning the contents of this document. This document shall be binding and will expire (1) one year from the date below.[Signatures of each adult requesting services]**

\_\_\_\_\_  
Signature (First & Last Name)

\_\_\_\_\_  
Signature (First & Last Name)

Witness/Therapist: \_\_\_\_\_

Date: \_\_\_\_\_



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**ICCS FINANCIAL AGREEMENT**

I, \_\_\_\_\_ request Interactive Counseling & Consulting Services Inc. (ICCS) to provide services in accordance to my ICCS Informed Consent & Contract for Services. I understand and agree to pay any and all fees for services at ICCS. **I agree to pay (\$35) for making a late cancellation that is not 24 hours in advance. I also agree to pay (\$50) for not showing to a scheduled appointment.** I agree to cancel any appointment within a **minimum of 24 hours** in advance of that appointment if I am unable to attend. I agree to pay the Returned Check Fee (\$30) if a check is drawn on insufficient funds at the time of deposit. I agree to pay for any additional services rendered at my request or of the request of my therapist. I understand and agree that professional services may not be reimbursable by insurance or third parties and fees are subject to change every 6 months. I understand that I will be billed and payment is due at the time of service.

- Phone/Webcam Consults** - \$2 per minute
- Professional Consults** - \$2 per minute
- Email Consults** - \$30 per page
- Short Informational Reply Emails (SMS)** - FREE
- Preparation of Forms or Letters** - \$35 per page
- Court Time** - \$300 per hour including travel time

**Counseling Session Information:**

<b>20-30 minutes</b>	<b>45-50 minutes</b>	<b>60-65 minutes</b>	<b>75 minutes</b>
<b>\$ 65.00</b>	<b>\$ 95.00</b>	<b>\$ 115.00</b>	<b>\$ 145.00</b>

**Please check one of the boxes below:**

**YES**, I wish to bill my Insurance \_\_\_\_\_. I understand coverage of insurance is not a guarantee of payment by my insurance and a billable diagnosis of a mental disorder will accompany all claims. I further understand I am ultimately responsible for any balance due to ICCS and that the fees with insurance are non-negotiable and have been contracted.

**Insurance Billing Disclaimer-**

Mental Health Coverage is often different from your medical policy. The below benefits are a description for a billable diagnosis of a mental disorder. ICCS can no longer guarantee that your Private Health Information (PHI) will be kept confidential once your information leaves ICCS. If you have questions or concerns, please don't hesitate to ask because your confidentiality is our utmost concern.

**NO**, I do not want to bill my Insurance or do not have insurance. I agree to pay all fees by cash, check, or credit card. I also understand a payment plan can be established with ICCS

<b>Office Use Only</b>	<input type="checkbox"/> <b>Insurance</b> <input type="checkbox"/> <b>In Network</b> <input type="checkbox"/> <b>Out of Network</b> <input type="checkbox"/> <b>Private Pay</b> <input type="checkbox"/> <b>Payment Plan</b>
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I have read, agree, understand, and have been advised by my licensed professional concerning the contents of this document. This document shall be binding and will expire (1) one year from the date signed.

**[Signatures of each adult requesting services]**

\_\_\_\_\_  
Signature (First & Last Name)

\_\_\_\_\_  
Signature (First & Last Name)

Witness/Therapist: \_\_\_\_\_

Date: \_\_\_\_\_