TRINITY COUNSELING CENTER

Kevin Richard, MA, NCC, LPC

Client Information

(please print)

Name: _____
First Middle Last

Address: _____ Cell Phone: _____

City, State, Zip: _____ Work Phone: _____

Parish: _____ Home Phone: _____

Check Preferred Contact: Cell____ Work ____ Home____ May we leave a message? Y___N___

I wish to have appointment reminders by: text message _____ e-mail _____ phone _____

Email: _____ Emergency phone: _____

Emergency Name/Relationship: _____

Date of Birth: ____/____/____ Age: _____ Gender: M____ F____

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed ____ Other

Employment Status: ____Employed ____ Unemployed ____Child/Student ____Disabled ____Retired

Employer (for children list parent's employer) _____

Who referred you? _____

Please list family members in the household and their relationship to you:

Name (First-Middle-Last)	Relationship	Age	Birth date

List immediate family members not in the home:

Name (First-Middle-Last)	Relationship	Age	Birth date

***Symptoms* Checklist:**

_____ Aggressive Behaviors	_____ Emotional Trauma	_____ Paranoid Ideas
_____ Alcohol Abuse	_____ Family History of Psychiatric Problems	_____ Phobias
_____ Alcoholism	_____ Excessively Negative	_____ Physical Impairment
_____ Anorexia	_____ Fatigue/ low energy	_____ Physical Trauma
_____ Anxiety	_____ Fibromyalgia	_____ Poor Grooming
_____ Appetite Disturbance	_____ Grief	_____ Self-mutilation
_____ Autism	_____ Guilt	_____ Sexual Abuse
_____ Back Problems	_____ Headaches	_____ Sexual Dysfunction
_____ Bingeing/Purging	_____ Hearing Impairment	_____ Sleeping Disorder
_____ Birth Defects	_____ Heart Disease	_____ Speech Problems
_____ Deafness	_____ Hopelessness	_____ Suicide Attempts
_____ Depressed Mood	_____ Medical Problems	_____ Venereal Disease
_____ Developmental Disability	_____ Mental Illness	_____ Weight Gain
_____ Diabetes	_____ Mental Retardation	_____ Weight Loss
_____ Drug Abuse	_____ Obsessions/Compulsions	_____ Worthlessness
_____ Drug Use		

Prior Psychotherapy/Counseling ____Yes ____ No **If yes, please provide information below.

Counselor_____ When _____ Diagnosis _____

Family History of Psychiatric Issues and/or Treatment

Relationship to client	When was treatment received	Diagnosis

Medical Information

Please provide the following information in regards to the client. If a child is the client, please complete the form for your child.

Medications

Please list all medications and the dosages you are currently taking:

Name of medication	Dosage	Prescribing Doctor

Primary Care Physician (PCP):

_____

Address of PCP:

_____

C**ounseling and Office Policies**

I understand:

- Payment in full is due prior to each session.
- **Except in emergency situations, failure to provide 24 hour notice of cancellation will result in a charge for ½ of the regular session fee for the failed appointment.** If necessary, I may leave a message on the Trinity Counseling Center voicemail for after hours and weekend cancellations.
- Fees for reports written for legal purposes will be the amount of a full session fee and ***must be paid prior to the reports being released*.** It is my responsibility to request a copy of court related documents.
- Clients with delinquent accounts will not be allowed to reschedule until payment in full for prior services has been made.
- Limitations to confidentiality as described in Kevin's **"Declaration of Practices and Procedures"**

In signing this, I consent to counseling services for myself and/or dependent and agree to the above office policies. I also acknowledge that I have been given a copy of Kevin Richard's "**Declaration of Practices and Procedures**" which includes information regarding the **counseling relationship, fees, emergency information, and limitations to confidentiality.**

Signature _____ **Date** _____

Signature _____ **Date** _____

CONSENT FOR TREATMENT OF CHILDREN AND ADOLESCENTS

I/We, being the parent(s) or legal guardian(s) for _____ a minor child, consent for counseling services to be provided by **Kevin Richard, MA, NCC, LPC.**

Signature _____ **Date** _____

Signature _____ **Date** _____

Kevin Richard, MA, NCC, LPC

Trinity Baptist Church
1800 Country Club Road
Lake Charles, Louisiana 70605
337-310-8421

Declaration of Practices and Procedures

Qualifications: I earned a Master of Arts degree in Professional Counseling from Liberty University in Lynchburg, VA in 2011. I am registered as a **National Certified Counselor and Licensed Professional Counselor #5091** with the Louisiana LPC Board of Examiners, 8631 Summa Avenue, Baton Rouge, LA 70809, (225-765-2515).

Counseling Relationship: I view counseling as a process in which you the client, and I the Counselor, have come to understand and trust one another. This trust enables us to work as a team to explore and define present problematic situations, develop future goals for an improved life, and work in a systematic fashion toward realizing and accomplishing these goals. The counseling relationship is one of commitment from both the client and the Counselor.

Areas of Focus: I have experience working with individuals, families, and groups on a variety of issues including crisis intervention, depression, anxiety, marital issues, social stressors, suicidal ideations, anger and stress management, bereavement, interpersonal relationships, trauma, and sexual and physical abuse.

Fee Scales and Office Procedures: Members of Trinity Baptist Church receive services at a discounted rate. The maximum fee for members is $30 for each 45-50 minute individual or family session, and $10 for each group session. The maximum fee for non-members of Trinity Baptist Church is $60.00 for each 45-50 minute individual or family session, and $20.00 for each group session. All fees are paid to Trinity Baptist Church and will be collected before each session.

Appointment times are specifically reserved for you. **Except in the event of an emergency, any cancellation or rescheduling of appointments made with less than 24 hours notice will result in you being charged ½ of the full session fee.** Arriving late does not extend the counseling hour.

Services Offered and Clients Served: The major theories and techniques I will utilize in my practice include, but are not limited to the following: cognitive-behavioral therapy, client- centered therapy, solution focused, and reality therapy. These approaches will be used to help clients identify strengths as well as problem behaviors and patterns, and then use those strengths in order to facilitate desired changes.

Code of Conduct: As a counselor, I am required by state law to adhere to the Code of Conduct for practice that has been adopted by the State of Louisiana LPC licensing Board. Copies of these codes are available to you upon request or at www.lpcboard.org.

Privileged Communication: Material revealed in counseling will remain strictly confidential except for the following circumstances in accordance with state law: **1)** The client signs a written release of information indicating informed consent of such release, **2)** The client expresses intent to harm him/herself or someone else, **3)** There is a reasonable suspicion of abuse/neglect against a minor child,

elderly person (60 or older), or a dependent adult, or **4)** A court order is received directing the disclosure of information.

It is my policy to assert privileged communication on behalf of the client. I will endeavor to apprise clients of all mandated disclosures as conceivable.

In the event of family or marriage counseling, material obtained from an adult client individually may be shared with the client's spouse or other family members only with the client's permission. Any material obtained from a minor client may be shared with the client's parent or guardian.

Emergency Situations: If an emergency situation should arise, you may seek help through hospital emergency room facilities or by calling 911.

Client Responsibilities: You, the client, are a full partner in counseling. Your honesty and effort are essential to success. If as we work together you have any suggestions or concerns about your counseling, I expect you to share these with me so that we can make the necessary adjustments. If it develops that you would be better served by another mental health provider, I will help you with the referral process. If you are currently receiving services from another mental health professional, I expect you to inform me of this and grant me permission to share information with that professional so that we may coordinate our services to you. In the counseling relationship, clients are generally responsible for **1)** following appointment-scheduling procedures, **2)** making an invested effort in the counseling process, **3)** and terminating one counseling relationship before beginning another.

Physical Health: Physical health can be an important factor in the emotional well-being of an individual. If you have not had a physical examination in the last year, it is recommended that you do so, and list any medications that you are now taking on the forms provided.

Potential Counseling Risk: The client should be aware that counseling poses potential risks. In the course of working together, additional problems may surface of which the client was not initially aware. Also, in marriage counseling, additional strain may be placed on the relationship if one client changes and the other refuses to work. If this occurs, the client should feel free to share these new concerns with me.