ηikaō counseling

Dr. Liz Casteel, M.A., LPC-S	***Ann Key, M.A., LPC-S***	***Rachel Hopkins, M.A., LPC-S***
Audrey Cook, M.S., LPC, NCC	***Martha Ryan, M.Ed., LPC***	***Josh Walsh, M.A., LPC-S***
Mike Holmes, M.A., LPC	***Molly Hatley, M.A., LPC***	***Brylee Bolton, M.A., LPC***
Chrissy Smith, M.A., LPC	***Samantha Klassen, Ph.D., LPC-S***	***Hazel Casteel, W.O.O.F.***

Date: _____ **Fee Assessed: $**_____

Adolescent Intake Information

Adolescent's Name: _____ _____ _____
(Last) (First) (Middle)

Home Address: _____ _____ _____ _____
(Street) (City) (State) (Zip)

Parent's Name: _____ _____ _____
(Last) (First) (Middle/Maiden)

Parent's Email Address: _____ Parent's DL#: _____

Parent's Phone: _____

Adolescent's Email Address: _____

Adolescent's Phone: _____

May I contact adolescent via: Email: Yes ☐ No ☐ Call: Yes ☐ No ☐

Text: Yes ☐ No ☐ Voicemail: Yes ☐ No ☐

If parents are divorced or deceased: Year Divorced: _____ Year Deceased: _____

Adolescent's DOB: _____ Age: _____ Sex: _____ Place of Birth: _____

Adolescent's School: _____ Current Grade: _____

Please list siblings (Clarify if living in home by "IN" beside name):

Name: _____ Age: ____ DOB: _____ Sex: ____ Biological ☐ Step ☐ Adopted ☐

Name: _____ Age: ____ DOB: _____ Sex: ____ Biological ☐ Step ☐ Adopted ☐

Name: _____ Age: ____ DOB: _____ Sex: ____ Biological ☐ Step ☐ Adopted ☐

Name: _____ Age: ____ DOB: _____ Sex: ____ Biological ☐ Step ☐ Adopted ☐

Name: _____ Age: ____ DOB: _____ Sex: ____ Biological ☐ Step ☐ Adopted ☐

Parent's employer: _____ Position: _____

Faith preference: _____ If you attend church, where: _____

Person to contact in case of emergency: _____ Phone: _____

Referral source: _____ / _____
(Name) (Address)

If someone referred you to our office, I would like to thank him or her for the referral. May I have permission to send a thank you note? Yes ☐ No ☐

Nikaō's session fee ranges from $175-$185 depending on the individual counselor. If you have a need for a sliding scale, please discuss with your individual counselor.

What is your major concern that led you to seek help?

What other concerns do you have?

Please describe any "yes" answers to the questions below.

Is your teen consistently down or do they have a depressed mood most of the day or nearly every day?

Yes ☐ No ☐

Does your teen have a diminished level of interest in most or all activities?

Yes ☐ No ☐

Change in appetite?

Yes ☐ No ☐

Change in weight?

Yes ☐ No ☐

If it's relevant for your treatment goals please provide current height and weight.

Height: _____ Weight: _____ Highest weight: _____ Lowest weight: _____

Any history of food bingeing?

Yes ☐ No ☐

Any use of laxatives ☐ diuretics ☐ diet pills ☐ purging ☐ food restriction ☐ ?

If yes, please describe.

Change in sleep pattern?

Yes ☐ No ☐

Fatigue or loss of energy?

Yes ☐ No ☐

Feelings of worthlessness or excessive guilt?

Yes ☐ No ☐

Difficulty thinking or concentrating?

Yes ☐ No ☐

Thoughts of death or suicide (or any attempts)?

Yes ☐ No ☐

Increased irritability or violent behavior?

Yes ☐ No ☐

Attacks of hyperventilation, palpitations or intense fear?

Yes ☐ No ☐

Any phobias or unusual fears?

Yes ☐ No ☐

Ever experience a “natural high” in absence of substance abuse (with increased energy, mood, decreased need for sleep, talkativeness, etc.)?

Yes ☐ No ☐

Do they or have they ever used recreational drugs?

Yes ☐ No ☐

Do they drink alcohol? If yes, how many drinks on average per week? Do you believe they have a problem with alcohol?

Yes ☐ No ☐

Is your teen in a relationship? If yes, please describe the nature of the relationship and how long they’ve been together.

Yes ☐ No ☐

If you feel comfortable answering this question, has your teen ever experienced any traumatic events as a child or young adult?

Yes ☐ No ☐

List any previous counseling experience: Name of counselor(s) and dates attended.

Any major medical problems (i.e. thyroid, diabetes, asthma, etc.)?

Yes ☐ No ☐

Any prior hospitalizations? (Please give dates, reasons, types of treatment.)

Yes ☐ No ☐

Name of your teen's Primary Care Physician: _____

Physician's Phone: _____

Date of last medical evaluation: _____

Has your teen been under the care of a psychiatrist? If yes:

Name: _____

Phone Number: _____

Date of last medical evaluation: _____

Current medications being taken:

Name: _____ Dosage/Frequency: _____ Start Date: _____ Purpose: _____

Name: _____ Dosage/Frequency: _____ Start Date: _____ Purpose: _____

Name: _____ Dosage/Frequency: _____ Start Date: _____ Purpose: _____

Name: _____ Dosage/Frequency: _____ Start Date: _____ Purpose: _____

Name: _____ Dosage/Frequency: _____ Start Date: _____ Purpose: _____

Prescribed by: _____

Research has shown that heredity plays a role in many disorders. Please take time to think of your teen's various blood related relatives. Indicate any who have had similar symptoms as your teen. Also, note if any had problems (even if no treatment was received) with the following: anxiety, depression, manic depression, changes in behavior or mood, eating disorders, phobias, suicidal behavior, drug or alcohol dependency, etc.). Please note any other emotional or medical problems.

Relative

Problem

Is there anything else that would be helpful for me to know about?

What do you hope or expect for your teen to gain from therapy?

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes regarding the above information.

PARENT/GUARDIAN SIGNATURE: DATE:

Dr. Liz Casteel, M.A., LPC-S	***Ann Key, M.A., LPC-S***	***Rachel Hopkins, M.A., LPC-S***
Audrey Cook, M.S., LPC, NCC	***Martha Ryan, M.Ed., LPC***	***Josh Walsh, M.A., LPC-S***
Mike Holmes, M.A., LPC	***Molly Hatley, M.A., LPC***	***Brylee Bolton, M.A., LPC***
Chrissy Smith, M.A., LPC	***Samantha Klassen, Ph.D., LPC-S***	***Hazel Casteel, W.O.O.F.***

NIKAŌ'S INFORM AND CONSENT

We are pleased that you have selected Nikaō Counseling Center for your counseling needs. This document is designed to inform you about our office policies and to ensure that you understand our professional relationship.

Nature of Counseling

We use an approach to counseling which takes into account the spiritual, psychological, social and biological dimensions of the client. The relationship we establish will be characterized by mutual respect and cooperation. Our mutual goal will be that you will grow, develop, and be committed to working on things we talk about both during our sessions and at home. Our ultimate goal is that you will come to a place of being able to resolve your own issues and/or live with manageable pain without our assistance or intervention. We will offer you tools in which you can utilize in the achievement of this goal.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads the client to having better relationships, solutions to specific problems, and significant reductions in feelings of distress. Please note, however, that it is impossible to guarantee any specific results regarding your counseling goals. Together, we will work to achieve the best results possible.

Confidentiality

The staff at Nikaō Counseling Center operates as a team to improve the quality of counseling. Because of this, the process of your counseling may be discussed with your counselor's colleagues and/or your counselor's supervisor and will remain confidential. All counselors with the title "LPC-Associate" are supervised weekly by their Texas Board Approved Supervisor. Everything that is communicated within our sessions is confidential information and cannot and will not be communicated to any other person or organization without your expressed written consent. This confidentiality applies to any and all records of your identity, diagnosis, session or progress notes, evaluation, treatment or treatment plan, as well as any information communicated by phone, fax, or email.

Please note: confidentiality will not be observed with respect to the following conditions:

1. You direct me by means of a signed and dated written consent form to disclose information to a person or organization of your choice, (please note: both parent's signatures will be required in order to release confidential information of a minor),
2. I determine your teen is a danger to themself or others, in which case I am required to inform a medical or a law enforcement agency,
3. I become aware of your teen's abusive or neglectful behavior toward a minor,
4. I become aware of your teen's abusive, neglectful, or exploitive behavior toward the elderly or disabled persons,
5. I am ordered by a court to disclose information,
6. I need to utilize the services of a collection agency for any unpaid balance (no clinical information will be provided, only contact information), or
7. I find it helpful to seek counsel from another mental health professional in order to help you more effectively seek recovery and emotional healthiness.

Initials: _____

I authorize my counselor to give out psychological information that is needed by my insurance company. This authorization for release is valid for the duration of the therapeutic relationship. I understand and agree that a diagnosis must be given, and that diagnosis will become a pertinent part of my records.

Initials: _____

Record Storage/Interruption of Services

In the unfortunate event of a counselor's death, incapacity, or the termination of their counseling practice, your records will stay in the custody of Nikaō Counseling Center, and you will be provided with recommendations for an appropriate referral.

Initials: _____

Obtaining Clinical Records

Under the Health Insurance Portability and Accountability Act (HIPAA), you have the legal right to request and receive your progress notes. These are part of your official medical record and can include clinical details, administrative information, and billing data. Please reach out to your therapist directly to discuss your needs.

Initials: _____

Technology

It is very important to be aware that computers, e-mail and cell phone communication can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication. E-mails in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, the emails sent from our computers/phones/tablets are not encrypted.

Nikaō counselors only use computers that are equipped with a firewall, a virus protection and a password. Please keep this in consideration when using your

computer/phone/tablet to communicate with our counselors. In addition, it is important for you to know that our office phone number is unable to receive text messages.

Initials: _____

Newsletter

Nikaō sends out a quarterly newsletter that covers current issues, topics, and trends that we all face in life. Would you like to be added to our email list? You can unsubscribe at any time.

Initials: _____

Weather Policy

In the event of a weather emergency, we defer to DFW school districts. If local schools are closed, no fees will be collected for cancelations of counseling appointments. However, your counselor may still be willing to meet either in the office or offer a phone or telehealth session if you would like. Your counselor will communicate with you regarding your appointment in the event of inclement weather.

Initials: _____

Fee Agreement and Cancellation Policy

Sessions are 50 minutes in length. Payment is due at the conclusion of each session. We accept cash, checks, MasterCard/Visa. Please make checks payable to your therapist. If there is a financial need, talk directly to your therapist. Receipts will be provided after each session should you wish to file insurance. Due to variations in policies, we cannot guarantee payment by your insurance company. If you lose your receipt and need a copy, there will be a $.50 charge per receipt. In addition, a $25.00 fee will be charged for all returned checks.

Should you need to cancel your appointment, please call or email your counselor at least 24 hours in advance.

Except for emergencies, the normal fee will be charged for missed appointments if not given 24 hours' notice. (Voicemail is available 24 hours a day, seven days a week). I understand that fees for all services are due at the time of my appointment. I also understand that the normal fee will be charged for missed appointments if my therapist is not given a 24-hour advance notice.

Initials: _____

I understand that my therapist will utilize the services of Financial Management of Arlington, Texas to collect any unpaid balance over 90 days.

Initials: _____

Nikaō Counseling Center is not a Medicaid approved provider, therefore their services are not reimbursed by Medicaid. I attest that I am not seeking Medicaid reimbursement.

Initials: _____

Therapy Dog

We wanted to make you aware that occasionally, Hazel, a therapy-trained Labrador Retriever is at the office around our clients and counselors. She camps out mostly in Liz Casteel's office but at times you may see her in the checkout area or greeting people in the waiting room. If this is bothersome to you for any reason, please let your counselor know so that Hazel can be kept in another office while you are here at Nikaō. We would not want Hazel to cause you to experience anxiety or discomfort in any way. Initialing below confirms that you are aware that Hazel is in our office space.

Initials: _____

In the Event of a Crisis or an Emergency

If you have an emergency, you can contact your therapist at 972-733-0050 and leave him/her a confidential voicemail at their extension. Please talk to your individual therapist about their protocol in returning phone calls after hours or on weekends. Some of our therapists only work certain days of the week so may not be available to address your urgent issue. If you cannot reach your therapist, and it is a life-threatening situation, please call 911 when necessary and appropriate.

Complaints

Services will be provided in a professional manner consistent with legal and ethical standards by the Texas State Board of Examiners of Licensed Professional Counselors and by the Texas State Board of Examiners of Marriage and Family Therapists. You have the right to have any complaints heard and resolved in a timely manner. If you have a complaint about your treatment, your therapist or any policies, please bring it to your therapist's attention so it can be resolved as quickly as possible. If a complaint is not resolved, the Texas State Board of Examiners of Licensed Professional Counselors can be reached at 1-800-942-5540 and the Texas State Board of Examiners of Marriage and Family Therapists can be reached at 1-888-963-7111. You also have the right to file a consumer complaint with the Texas Attorney General. That can be done through their website: https://www.texasattorneygeneral.gov/consumer-protection.

Your Signatures Below: I have read and understand the above office policies. I have also been given a copy of the "Inform and Consent" document to retain for my personal files.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____
(if client under 18 years of age)

SIGNATURE OF SPOUSE: _____ DATE: _____
(must have both parents' signatures)