Christian Counseling Services, LLC
1116 West State Highway 152
Mustang, OK 73064
918-331-8215

CLIENT INFORMATION

NAME: **RACE/GENDER:**

ADDRESS: **CITY/STATE:** **ZIP:**

DATE OF BIRTH: **SOCIAL SECURITY #:**

PHONE:

PRESENTING PROBLEM:

EMERGENCY CONTACT: **PHONE NUMBER:**

REFERRED BY:

EMPLOYER:

CO-PAY: $40.00

CURRENT MEDICATIONS:

Date of Intake:
Diagnosis and code:
Patient Control Number: Updated: 3/1/2023

Christian Counseling Services, LLC
Rick Woodward, LPC
1116 West State Highway 152
Mustang, OK 73064
918-331-8215
Email: rick@rickwoodward.com

CLIENT'S RIGHTS

As a client of Christian Counseling Services, you have certain rights that are set out in the OKDMHSAS Title 450, Chapter 15 Consumer Rights. Also, a written policy describes what this program must do to comply with said rights. A summary of rights are below:

1. Each consumer shall retain all rights, benefits and privileges guaranteed by law except those lost through due process of law.
2. Each consumer has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation.
3. No consumer shall be neglected or sexually, physically, verbally or otherwise abused.
4. Each consumer shall be provided with prompt, competent and appropriate treatment and an individualized service plan. A consumer shall participate in his or her treatment programs and may consent or refuse to the proposed treatment. The right to consent or refuse to consent may be abridged for those consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. Additionally, each consumer shall have the right to the following:
   A. Allow other individuals of the consumers choice to participate in the consumers treatment and with the consumers consent.
   B. To be free from unnecessary, inappropriate or excessive treatment.
   C. To participate in consumer's own treatment planning.
   D. To receive treatment for co-occurring disorders, if present.
   E. To not be subject to unnecessary, inappropriate or unsafe termination from treatment.

5. Every consumer's record shall be treated in a confidential manner.
6. No consumer shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.
7. A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.
8. Each consumer has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.
9. No consumer shall be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his or her rights.

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MISSION STATEMENT

Christian Counseling Services offers service to children, adolescents, adults and families. Christian Counseling partners with other agencies for the best interest of the client/family. Listening, encouraging and offering hope are my values as a therapist. My desire is to help individuals and families work through life's problems. I have faith and believe in the individuals I work with and in Jesus Christ who is the true healer.

It would be my pleasure to provide confidential, non-judgmental counseling services to you and your family. I utilize cognitive behavioral, motivational interviewing and strengths based counseling therapies as well as art and music psychotherapies. I provide counseling in the areas of anxiety, depression, relationships, substance abuse and trauma. I also provide letters to your physicians for suggested medications based upon testing and therapy notes.

Client Signature:_______________________________________ Date:_______________

Parent Signature:_______________________________________ Date:_______________

Counselor's Signature:___________________________________ Date:_______________

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Agreement To Follow Rules of Conduct

Upon my acceptance of services, I agree to follow the rules of conduct as follows:

- To cooperate with admission procedures which includes: intake interview, verification of funding eligibility, intake assessment, treatment planning and program acceptance form.
- To wear a seat belt when riding in a vehicle owned by staff of Christian Counseling Services.
- No weapons of any kind allowed on property of Christian Counseling Services.
- No alcohol or drugs allowed on property of Christian Counseling Services.

Client Signature:_________________________________ Date:____________

Parent Signature:_________________________________ Date:____________

Counselor's Signature:_____________________________ Date:____________

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24 Hours Cancellation Policy

I understand that I will be expected to pay the $40.00 hourly charge for not cancelling my appointment 24 hours before my scheduled appointment. I understand that I will need to be prepared to pay the hourly fee before I will be seen in the office again.

Client Signature:_______________________________________ Date:_______________

Parent Signature:_______________________________________ Date:_______________

Counselor's Signature:___________________________________ Date:_______________

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LIMITS OF PATIENT CONFIDENTIALITY

1. You are a danger to yourself or others.
2. You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
3. Your counselor was appointed by the courts to evaluate you.
4. Your contact with your counselor is for the purpose of determining sanity in a criminal proceeding.
5. Your contact is for the purpose of establishing your competence.
6. The contact is one in which your counselor must file a report to a public employer or as to information required to be recorded in a public office, if such report or record is open to public inspection.
7. You are a senior citizen and your counselor believes you are a victim of physical abuse. Your counselor may disclose information if you are the victim of emotional abuse.
8. You file suit against your counselor for breach of duty.
9. You have filed a suit against someone and have claimed mental/emotional abuse.
10. You waive your rights to privilege to give consent to limited disclosure by your counselor.
11. Your insurance company paying for services has the right to review all records.

*If you have any questions about these limitations, please discuss them with your counselor.

Signed:______________________________________ Date:_____________

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AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

Client Name:___________________________**DOB:**____________ **ID#**_________________

Information to be released by/to:
Christian Counseling Services 1116 West State Highway 152 – Mustang, Okla. 73064
Information to be released by/to:
Name:_______________________________________

Address:_____________________________________

Phone:_______________________________________

Relationship to client:___________________________

Specific Information To Be Released or Exchanged:

____Hx and physical exam	_____Mental Status	______Family Systems Eval
____Discharge Summary	_____Treatment Plans	______Nursing Notes
____Psychiatric Evaluation	_____Progress Notes	______Consultation Reports
____Psychological Test Results	_____Therapist Notes	______Educational Records
____Chemical Recovery Hx	_____Diagnosis	______Educational Tests
____Court/Agency Documents	_____Crisis Inter. Report	______Dates/Hospitalization
____Medical Records	_____Psychosocial Report	

Other (specify):____

- This release of information form will expire one year from the date signed.
- Records are kept confidential in accordance with state and federal law.

____
Client/Authorized Representative Signature Auth Rep Title Date

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Parent/Caregiver Acceptance Form

I, ______________________________________, agree to accept services from Christian Counseling Services, LLC.

- I will be an active part of the treatment process, and am thereby expected to work cooperatively with the assigned counselor.
- I have received copies of the mission statement, human rights guidelines, confidentiality limitations and grievance procedure, emergency procedures and other relevant documents.
- Office hours, phone numbers and crisis after hours numbers have been received.
- Per mutual agreement, that the client may be transported by the counselor at no liability to the counselor or Christian Counseling Services.
- In acceptance with receiving services from Christian Counseling Services.

Parent Signature:___________________________________ Date:_________________

Counselor's Signature:_______________________________ Date:_________________

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Fee Agreement for Mental Health/ Substance Abuse Services

Fees for counseling Services are due prior to service provisions.

- Intake - $100 (includes assessment and treatment plan) usually waived
- Written report including assessment findings and recommendations - $100
- (if requested) for court or PO - not covered by insurance.
- Court appearance $1,000 plus $.55 cents per mile - not covered by insurance.
- Individual or Family Counseling - $40.00 an hour - $10 per 15 minutes after the first hour.

Refunds will not be given for missed appointments. A no show fee of $40.00 will be assessed on missed individual counseling appointments if 24 hour notice is not given Future individual appointments will not be scheduled until no show fees have been paid.

Accepted payments methods:

- **Cash**
- **Personal Check ($25 fee for all returned checks)**
- **Money Order**
- **Venmo, Cash Ap, PayPal**

I understand and acknowledge that I am entering into a contract with Christian Counseling Services, LLC to receive counseling services. I have read the above fee schedule and agree to the fee structure set forth in this document.

____

Client Signature **Date**

Rev 3/1/2023