

ADOLESCENT INTAKE

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Who are you presently living with? _____

School: _____ Grade: _____

Hobbies: _____

Job: _____

Do you believe in God? Yes No What is your present religious preference? _____

What concerns have brought you to counseling today? _____

PROBLEMS CHECKLIST

Please Rate Each Issue With a Number: 1 = Major Problem 2 = Sometimes a Problem 3 = Never a Problem

- _____ Feeling accepted by my peers
- _____ Learning how to trust others
- _____ Feeling bad about the way I look/my body
- _____ Getting along with my parents or other family members
- _____ Getting a clear sense of what I value
- _____ Worrying about whether I'm normal
- _____ Dealing with sexual feelings and/or problems
- _____ Excessive worry or anxiety
- _____ Trying to decide on a career
- _____ Never eating/eating too much and vomiting to control weight
- _____ Dealing with my alcohol or drug abuse
- _____ Dealing with problems at school
- _____ Dealing with how I feel about myself

Are there any other problems or concerns you would like to address? _____

Cheryl La Mastra, M.A., LPC

CONSENT FOR COUNSELING OF MINORS

Name of Parent/Guardian _____

Name of Minor _____

Minor's Date of Birth _____

Name of Counselor _____

License Type: LPC

This is to certify that I give permission to **Cheryl La Mastra** for treatment of my child. This counseling may include individual or family psychotherapy, counseling, and testing. This counseling may also include referrals to other appropriate state and county or professional agencies for further consultation, if necessary.

I hereby waive my right as a parent to obtain information from and copies of any records from Cheryl La Mastra, M.A., LPC pertaining to the evaluation and treatment of the following child: _____, age _____. I understand that Cheryl La Mastra *may* refuse to provide me, or any third party acting upon my request or authorization, with information and records pertaining to this child's mental health evaluation and treatment, if disclosure in the opinion of the child's therapist would negatively impact the child or the child's evaluation and treatment. I hereby release Cheryl La Mastra, M.A., LPC from any and all liability for good-faith refusal to disclose the child's information or records.

Signature of Parent/Guardian _____ Date _____

Street Address _____

City/State/Zip _____

Home Phone _____ Work Phone _____

Emergency Contact (Other than yourself):

Name _____ Phone _____

Witness/Title/Date _____

Cheryl La Mastra, M.A., LPC

Client Rights & Responsibilities

METHOD OF TREATMENT

Counseling methods combine brief, solution-focused therapy with Biblical principles and an emphasis on relational dynamics. A positive approach to problems is taken, believing that people are resilient and have tremendous resources to address life situations. It is the role of the counselor to help the client understand the dynamics of his situation and to assist him in using his particular strengths to address these issues.

Cheryl La Mastra adheres to the belief that every client should have the right to complete restoration along with God-given, and yet often unrealized freedoms.

GOALS, RISKS & BENEFITS

There is always a risk of emotional side effects from counseling. *Sometimes symptoms worsen before they get better.* Often counseling brings up painful emotions. Cheryl La Mastra's goal is to confront issues and emotions together and to work through them over time. Other types of counseling such as support groups or therapy groups may also be appropriate in a particular situation. Together, the client and counselor will determine if one or more types of counseling are appropriate.

LENGTH OF TREATMENT

Length of treatment will vary and will be determined together by the client and counselor. Each individual and relationship has unique strengths and weaknesses, and each problem is different from the next. The goal is that each client will finish counseling in a timely manner, without unnecessary use of time or money. Groups will have a pre-determined number of sessions, typically six to ten.

FEES

Together, the client and counselor will make decisions concerning how often and for how long they should meet. Counseling sessions will be 45-50 minutes long at a cost of \$125 for initial session, \$115.00 for individual sessions. Marriage, and pre-marital sessions are \$120.00 per session and \$125 for family sessions. Personal checks, credit cards, and cash are accepted for payment. Payment is due in full at each session,

Insurance may reimburse all or part of counseling fees. Cheryl La Mastra does not file insurance; however, documentation is provided should the client choose to file with his insurance provider.

All fees incurred for lost time/wages because of court hearings, subpoenas served, or other legal matters regarding client(s) business will be paid in a timely manner by the client(s) signing below. Wages to be paid will consist of \$220/hr minimum.

Keep your receipts in a safe place for insurance/tax purposes. Clients sometimes ask for additional copies of receipts. While we are happy to be of service to you, this is a time consuming process for our administrative staff. Therefore, like other organizations, we charge a **\$10** fee for this service, to cover the cost of labor, copying, and postage or fax.

CANCELLATIONS

In the event the client is unable to keep an appointment, notification is required at least 24 hours in advance. The client is required to pay for any missed sessions unless he calls 24 hours in advance to cancel the appointment. An exception may be made if Cheryl La Mastra deems the situation an emergency.

RIGHT TO PRIVACY/CONFIDENTIALITY

All communication between the client and counselor becomes part of the clinical record. Records are the property of Cheryl La Mastra in accordance with legal requirements, adult client records are disposed of seven years after the file is closed; minor client records are disposed of seven years after the client's 18th birthday.

While most communication between a client and counselor is confidential, the following limitations and exceptions do exist:

- The counselor determines the client is a danger to himself or someone else.
- The client discloses abuse, neglect or exploitation of a child, elderly or disabled person.
- The client authorizes the counselor to release records.
- The counselor is ordered by a court to disclose information.
- The counselor is otherwise required by law to disclose information. *In marriage or family counseling, the meaning the confidentiality belongs to the relationship and not the individual.*

EMERGENCIES

During office hours, the client can contact the counselor at **972/400-7422**. If the client is unable to reach his counselor in a timely manner, client should contact his physician, a local emergency room or the local police department when necessary and appropriate. It is the client's responsibility to seek the appropriate resources in emergency situations.

By your signature below, you indicate that you have read and understood this statement, and any questions about this statement were answered to your satisfaction. You also indicate that you have received a copy of this statement for your records. By your counselor's signature, Cheryl La Mastra verifies the accuracy of this statement and acknowledges our commitment to conform to its specifications.

Client or Guardian Printed
Signature: _____ Name: _____ Date: _____

Counselor Printed
Signature: _____ Name: Cheryl La Mastra, M.A. LPC Date: _____

La Mastra Counseling

2800 North Dallas Parkway, Suite 220
Plano, Texas 75093
972-400-7422

No-Show and Cancellation Agreement

In an effort to provide excellent client service to all of our clients, and to provide the best possible therapeutic environment, it is our policy to require a fee for no-show appointments and cancellations made less than 24 hours in advance of the scheduled appointment. *

The fee of \$115.00 will be charged to the following credit card:

_____ **Visa** _____ **MasterCard**

Credit Card #: _____

Expiration Date: _____

Zip Code of where billing statement is sent: _____

Security Code (3 digits on back of card): _____

Name as it appears on Card: _____

I, _____, understand and agree that if I do not show up for my scheduled appointment or if I cancel my scheduled appointment with less than 24 hours notice, the above named credit card will be charged in the amount of \$_____. _____.

Signature _____ **Date** _____

Printed Name _____

Address: _____ Daytime Ph.: _____

City: _____ Zip: _____

*Exceptions for emergencies are determined by your counselor.