CrossRoads Counseling Centers

Phone: (314 469-5522 Fax: (314) 469-5504
http://www.stl-ccc.org

1023 Executive Parkway Dr., Ste. 10
St. Louis, MO 63141

4228 S. Kingshighway Blvd.
St. Louis, MO 63109

FOR OFFICE USE ONLY

Fee_____ Diag. Code_____ Diag. Rec._____ Ins. Pay_____ Copay_____ 1LUC/ADL_____

Date: _____

Referred By: _____

Therapist: Intern – Rebecca Angle

PERSONAL INFORMATION

Full Name: _____ Date of Birth: _____ Gender _____

Address: _____ City _____ State_____Zip_____

Soc. Sec. # _____ - _____ -_____ Cell/Home Phone _____

Education: ____High School ____College ____Other_____

Occupation: _____ Employer:_____

Church Home: _____ ___Active ___ Moderate ___ Inactive

Email Address _____

FAMILY INFORMATION

Marital Status: ____Single ____Married ____Divorced/Separated ____Widowed

Spouse's Name:___ _____ Phone # _____

Spouse's Occupation: _____ Employer_____ Phone # _____

Children: Name _____ Age ____ Name _____ Age ____

Name_____ Age____ Name _____ Age ____

Previous Marriage (s): Name(s) _____ Duration _____

FAMILY OF ORIGIN HISTORY

What number child were you in your family? _____ of how many? _____

What number child was your current spouse? _____ of how many? _____

Did anyone in your family ever experience physical, sexual, or emotional abuse? Please explain.

_____

_____

Have you ever felt that you were abused? Please explain.

_____

_____

Was anyone in your family a substance abuser?

_____

HEALTH INFORMATION

Your current health Very good Good Average Declining

Approximate date of your last comprehensive exam: _____

Current medical problems and/or medications. _____

Have you previously sought counseling? ____Yes ____ No

Therapist_____ Profession _____ From _____ To _____

Therapist_____ Profession _____ From _____ To _____

How satisfactory was your experience(s)?_____

_____

CONSENT FOR TREATMENT

Client Name_____

Date of Birth_____

Counselor – Rebecca Angle

I give permission to Rebecca Angle to provide counseling to me.

As a client of our office, it is your right to have the content of your therapy sessions held in confidence with these exceptions in which we are mandated to report: 1) if you sign a release form for us to divulge any or all information, 2) if you intend suicide, or if you intend to do serious physical harm to yourself, 3) if you intend homicide, 4) in the case of child, older or handicapped abuse, 5) in the case of exploitation by a mental health therapist.

In some cases, the Missouri courts have held that if an individual intends to take harmful or dangerous action against another individual, it is the counselor's duty to warn the person and/or the family of the person who is likely to suffer the results of harmful behavior.

Every effort will be made to resolve these issues before such a violation of confidentially takes place. Every effort will be made to prevent an attempted suicide or a dangerous action against another person.

I have read and agree to the above policy, procedure and statement.

_____ _____ _____

Signature of Client Printed Name of Client Date

_____ _____ _____

Signature of Client Printed Name of Client Date

_____ _____

Signature of Counselor Date

CrossRoads Counseling Centers
1023 Executive Parkway Dr., Suite 10
St. Louis, MO 63141
(314) 469-5522
Fax (314) 469-5504

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and as applicable law permits the terms of this Notice at any time, reflecting such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give use an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best

interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may need to disclose your health information, if required by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights
Access: You have the right to look at or get copies of your health information, within limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $25.00 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare as summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you requested this accounting more than once in a 12-month period, we may charge you reasonable, cost-based fee for responding to these additional requests.
Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of you health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this Notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. You may complain to us using the contact information listed at the end of this Notice.

We support your right to the privacy of your health information.

Contact Officer:	Business Manager	
Telephone:	314-469-5522 Ext. 14	Fax: 314-469-5504
Address:	1023 Executive Parkway, Suite 10	
	St. Louis, MO 63141	

CrossRoads Counseling Centers'
View of the Counseling Process

The practice of counseling is based upon particular theoretical orientations as well as the personal style and experience of the counselor. Therefore, we believe it is in your best interest to briefly explain to you our background (as a group) as well as our views of the counseling process.

We view the counseling process as forming an alliance with you, to explore the nature of your problem. Although we will spend much of our time exploring the specific problem that brought you into counseling, we will also explore, in depth, the nature of your relationship with other significant people in your life. In our theoretical orientation, we believe that many of the forces and dynamics that have influenced the complexity and intensity of your problem are rooted in relational issues. In using a Biblical foundation in our counseling, we believe you are made to deeply relate—this is both a source of great joy and of deep pain. This is not to simplify your problem, but rather to highlight the complexity of the problem and how it interferes with the deep enjoyment for which you have been made. Aiming at the source of the problem is meant to give you hope.

Interpersonal relationships are the areas in which the result of the brokenness of humankind is most prevalent, and in which the need for change is most obvious. In working toward the goals of removing the initial problem and growing in relational maturity, the counseling process will require that firm effort is made to change, which may involve significant discomfort. Remembering and resolving unpleasant events can arouse intense fear, anger, depression, frustration, and other powerful emotions that may feel foreign, but are a normal part of the process of growth. Seeking to resolve issues between family members, marital partners and other persons can similarly lead to discomfort, as well as relationship changes that may not have been originally intended.

Many of the results of counseling will depend upon your determination to deal honestly with the issues that powerfully affect your life. We are human beings who have been profoundly affected by the effects of brokenness in the world. We are damaged people who do further damage through the way we handle our pain. We are tempted to transform our thirst for intimacy into things under our control that keep us feeling protected, yet, at the same time, in agony. This pain often appears in the form of symptoms such as depression, eating disorders, sexual dysfunction, workaholism, anxiety, rage, etc. Your symptoms are important. They point beyond themselves to the need for an inside look into your life. This "inside look" is intended to surface—and over time disrupt—old, unhealthy dependencies and to offer the enticing idea that dependency on God is an invitation we have both feared and longed for in the core of our souls. We believe that certain problems can also have (or develop) physical components. In such cases, medical consultation will be advised.

The course of therapy is determined mutually by your counselor and you, the client. You are encouraged to freely ask any questions you have regarding the educational and professional background or therapeutic approach of your counselor. You are also encouraged to freely ask questions pertaining to your specific therapy plan and progress. **People often ask how long they will be in counseling.** Some clients need fairly brief therapy to understand their conflicts and reach the goals they set for themselves. However, others may require many months or even years of work to achieve the growth they desire. We attempt to work with people in such a way that they have sufficient time to meet their individual therapy goals, but we discourage clients from becoming inappropriately dependent upon therapy. Consequently, treatment duration varies from person to person. Clients typically know when they are beginning to "feel finished" with therapy work. When this happens we encourage you to discuss this with your counselor so that we can close our relationship as carefully as it began. State certification requirements for professional counselors do not imply the effectiveness of treatment. It is your responsibility to determine whether the services offered are appropriate and ultimately helpful.

It is always our intention to provide services in a professional manner that is consistent with all accepted ethical standards. If at any time in the course of your work with a counselor you feel that there may have been a misunderstanding or you have a question or complaint about your counselor's services, please bring this up immediately so that your counselor can become aware of your concern and resolve the matter with you.

Client Agreement and Treatment Consent

First of all, we would like you to know that we very much appreciate your willingness to help in the CrossRoads Counseling Centers and Covenant Seminary College professional development and training of Christian counselors. We trust that you will truly benefit from the intensive, supervised Christian counseling experience which you have elected to engage in. For your willingness to participate in this program, you will receive services at a substantially reduced rate.

We want to assure you that CrossRoads Counseling Centers and Covenant Seminary College have endeavored to select only highly qualified graduate interns for this special training program. To insure that your personal counseling needs are met with an appropriate level of care, your graduate student therapist will receive regular supervision by Tracie Wallace, MAC, LPC here at the counseling center, along with supervision by _____ at Covenant Seminary College. Any unexpected changes to this arrangement will be explained to you in a timely manner. Supervisory personnel at CrossRoads Counseling Centers and Covenant Seminary both reserve the right to suggest alternative courses of treatment; including referral to resources outside of this agreement should they ever deem that to be in your best interest.

Your confidentiality will be protected under the same code of ethics which governs licensed clinicians. There will be no communication about your situation or your family to any third party without your permission. However, in the rare situation, where the intern believes that you may be a danger to others or yourself, confidentiality may be broken in order to take whatever precautionary action that may be necessary. This will be done in discussion with the supervisor. Only your therapist and her / his immediate supervisors will have any specific knowledge of your case.

If your counseling needs continue beyond the course of your therapist's internship at the center, Covenant Seminary and CrossRoads Counseling Centers will work cooperatively together to provide you with one of the following options: 1) continuing with your current therapist in another location, 2) continuing through an extension of your therapist's time at CrossRoads or 3) by transferring your case to another therapist at CrossRoads Counseling Centers.

Any disputes or modifications of this agreement shall be negotiated directly between the parties involved; if negotiations are not satisfactory, then the parties agree to mediate any differences with a mutually acceptable third-party mediator. Furthermore, I (client) agree to indemnify and hold harmless Covenant Seminary and CrossRoads Counseling Centers, their agents, servants or employees from any claim for damages of any nature arising out of, or allegedly to, any counseling, instruction or advice rendered by personnel of Covenant Seminary and CrossRoads Counseling Centers or any activity related thereto.

I have read, discussed, and fully understood the terms of this contract.

Signed: _____Date: _____

Printed Name: _____
(Client)

Signed: _____Date: _____

Printed Name: _____
(Graduate Student/Intern)

Signed: _____Date: _____

Printed Name: _____
(Supervisor: Covenant Seminary College)

Signed: _____Date: _____

Printed Name: _____
(Supervisor: CrossRoads Counseling Centers)

Recording of Counseling Sessions
Counselee Consent

I, _____, hereby give my consent and permission to Rebecca Angle of Covenant Seminary College and CrossRoads Counseling Centers to record any and all counseling sessions between myself and Rebecca Angle. I also give my consent and permission for these recordings to be played and discussed in supervision and staffing sessions within CrossRoads Counseling Centers. I understand that my name will not be used in these discussions. I agree to hold the above named individuals, agency, and College harmless of any liability in the proper and prudent use of these recordings.

_____ _____
Counselee Date

_____ _____
Counselee Date

CrossRoads Counseling Centers

763 S. New Ballas Road, Suite 340
St. Louis, MO 63141-8787
(314) 872-2972

PAYMENT POLICY AND MISSED APPOINTMENTS

Welcome to CrossRoads Counseling Centers. Please take a few minutes to acquaint yourself with our policies.

Before any of us subscribe to a service, we must determine the costs and conditions of that service. As you come in for counseling, no doubt you have preliminary questions about costs, services, and billing. Those questions are appropriate, respectful, and reflect your good sense.

PAYMENT FOR SERVICES: Counseling sessions usually run 50 minutes. Our standard fee is $10.00; additional time billed to the quarter hour. Our usual practice is to ask clients to pay as we proceed***. Please put payment on your therapist's desk at the beginning of your session.*** Where insurance is applicable, we will provide you with a diagnostic receipt that you may file with your insurance company who will reimburse you. Our services are covered under many insurance programs, but please note that: a) some companies do not reimburse for our services and, b) insurance coverage policies are often changing. This means you are responsible for insurance questions. We may be able to assist, but you are ultimately responsible to ascertain coverage and initiate filing diagnostic receipts. Such receipts are given upon request.

MISSED APPOINTMENTS: Your cooperation in keeping scheduled appointments is expected. If you cannot be present for an appointment, it is necessary that you notify your counseling intern at least 48 hours in advance. We dislike charging for broken appointments, *but you can expect to be charged if you fail to give the appropriate (48 hours) notice.*

If you have any questions at all, please feel free to ask—your questions and comfort are always important.

I HAVE READ AND AGREE TO THE ABOVE POLICIES.

Signed_____ Date _____

Signed_____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Please Print Name) _____

(Signature) _____

(Date) _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)\