**Dr. Michael Russell**

207 Rock Prairie Road, Suite B, College Station, TX 77845

Individual & Marital Therapy 79.693.3393

Intake & Information Form drrussell.lpc@gmail.com

**New Client Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Client’s Full Name** |  |  |  |
| **Today’s Date** | **Date of Birth** | **Marital Status** | **Social Security Number** |
| **Home/Cell Phone Numbers** |  | **Work Number** |  |
| **Local Address** |  |  |  |
| **City** |  | **State** | **Zip Code** |
| **Permanent Address (if different)** |  |  |  |
| **City** |  | **State** | **Zip Code** |
| **Employer and/or School** |  |  |  |
| **Primary Physician** |  |  | **Phone Number** |
| **Current Medications** |  |  |  |
| **Referred by** |  | **Reason for Referral** |  |
| **Emergency Contact** |  |  | **Phone Number** |
| **Reason for Seeking Counseling** |  |  |  |
| **Are Spiritual Matters Important** |  | **Religious Affiliations** |  |
| **Insurance Carrier** |  |  |  |
| **Additional Information (if any)** |  |  |  |

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*Office: 979.693.3393 Fax: 979.694.7337 Email: drrussell.lpc@gmail.com*

**New Client Information:** It is my desire to serve you and your family with personal, competent, and ethical mental health services. To do so, I need to advise you of the services I offer and my offices policies.

**Credentials:**

* D.Min., 2004, Trinity Seminary
* M.A. 1986, Denver Seminary
* B.S., 1982, Indiana State University
* Licensed Professional Counselor, 1990

**Services**

* Individual counseling for adolescents and adults
* Marriage and family counseling
* Parent consultation
* Critical Incident Stress Management, Traumatic stress resolution
* Value-based counseling founded on biblical principles

**Usual and Customary Fees:**

* Initial Diagnostic Interview/Assessment
* Counseling and Consultation Services
* Legal Testimony

$150 (50 minutes)

$110 (50 minutes) / $50 (25 minutes)

$250 (preparation and court time)

**Payment:**  **Fees are due and payable in full at the time of service. I do not accept Third-Party payments from insurance carriers.** All other financial arrangements are made on a limited, individual basis. Please talk to me personally if special fee arrangements are needed. When there is a balance due on your account, you will receive a monthly statement. If you have difficulty paying your bill, please let me know and I will make every reasonable effort to work out a payment schedule. I hope this explanation helps you understand the business side of your counseling experience so we can focus on your reasons for seeking help. If you have any questions, please ask.

**Appointments:** All services are available only by appointment. When it is necessary for you to cancel an appointment, **please give notice at least 24 hours in advance of your scheduled time. A fee will be assessed for failure to cancel an appointment in a timely manner.**

**Emergency Calls:** As part of my service to you I will seek to be available to speak with you when necessary. If you wish to speak with me between visits, call my office number and leave a message for me to call you back. In an emergency situation, you may request that I be paged through my voice mail system. Please be sure to leave detailed information including phone numbers and times you can be reached. I will make every effort to return your call as soon as possible. If I am out of town or otherwise unavailable, another therapist will return your call and assist you. In a life-threatening emergency, always call 911 and your family physician in addition to contacting me.

**Limits on Patient Confidentiality:** As your therapist, I respect your right to privacy, especially regarding information you share in sessions. It is also important that you fully understand the limitations of confidentiality in order for you to make an informed decision regarding the information you disclose. I may be require by law to disclose confidential information if any of the following conditions exist: You are evaluated to be a danger to yourself or others; I was appointed by the court to evaluate you; you are a minor, elderly, or disable and I believe you to be the victim of abuse or you disclose information about such abuse; you file suit against me for breach of duty; you waive your rights to privilege or give consent to disclosure of information by me. Other circumstances in legal proceedings may require disclosure of confidential information. If you have any questions about these limitations of confidentiality, please discuss them with me.

**Patient/Guarantor Responsibility & Signature-On-File Statement:** I have read the fee policy stated above, and I understand and acknowledge that counseling and psychological services rendered and charged to the patient are the responsibility of the patient and/or guarantor. ***I hereby guarantee payment in full for services to be rendered by Dr. Russell to or on behalf of the patient.*** Patient and/or guarantor agrees to pay for services at the time they are rendered. Should collection efforts be necessary, all agency and/or attorney fees incurred will be the responsibility of the patient and/or guarantor.

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Patient /Parent Signature Witness Date