



WELCOME

Please print out these documents and take a few moments to complete them before your first visit:

- 1) Fill out and sign the top “New Client Information Form”
(all family members over 18 years of age will need to sign);
- 2) Read and sign the back of the “Declaration of Practices and Procedures” form *(the second copy is for you to keep; all family members over 18 years of age will need to sign the submitted copy);*
- 3) Retain the “Fee Sheet”; and
- 4) Fill out and return the “Extended Information Form”
(for couples, please print out two copies so each can submit a separate form)

THANK YOU

COUNSELING SERVICES OF AUSTIN, LLC
NEW CLIENT INFORMATION FORM

11-15-10

Asa R. Sphar III, Ph.D. and Associates - Individual/Marriage/Family Therapists

We appreciate this opportunity to serve your counseling needs. Please take a moment to provide us with the following information.

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Can we call you at work? Y / N Email: _____

Place of Employment: _____ Occupation: _____ Education: _____

Age: _____ Birth Date: ___/___/___ Social Security #: _____ Marital Status: _____

Approximate **Gross** Family Income Per Year or That of the Sponsoring Third Party: _____

Briefly describe your reason(s) for seeking help: _____

When were you last examined by a physician? _____ Name of Physician: _____

Phone: _____ List any medications you are now taking: _____

Have you ever received psychiatric or psychological help or counseling of any kind before? Y / N

If yes, please explain: _____

List the members of your family and all others in your home:

<u>Name(s)</u>	<u>Age/Birth Date</u>	<u>Relationship</u>	<u>Occupation</u>	<u>Place of Employment</u>
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Who referred you to this office? _____

Name of person to contact in case of emergency: _____ Phone: _____

*If you believe insurance may cover a portion of your visits here, please complete the following information:

Name of Insurance Company: _____ Phone: _____

Group #: _____ Policy Holders S.S.#: _____ Policy #: _____

By signing this document I attest that the above information is accurate and that I have also been given both Dr. Sphar's "Declaration of Practices and Procedures" and his "Fee Sheet".

Client(s) signature(s): _____ Date: ___/___/___

_____ Date: ___/___/___



Asa R. Sphar III, Ph.D., LPC, LMFT
2499 S. Capital of Texas Hwy.
Building "A"; Suite 200
Austin, TX 78746
512-351-4933

DECLARATION OF PRACTICES AND PROCEDURES

Welcome to my practice. I am pleased to have the opportunity to serve you and hope that this handout will provide information helpful in making an informed decision concerning my services.

Qualifications - In addition to my private counseling practice, I served for 14 years on the faculty of the New Orleans Baptist Theological Seminary (NOBTS) as Chair of the Psychology and Counseling Department and as Director of Clinical Training. I hold a master's degree in Marriage and Family Therapy, a Master of Divinity (M.Div.) and Doctor of Philosophy (Ph.D.) degrees in Psychology and Counseling and was the recipient of the Outstanding Student and Broadman Seminarian Awards for my graduating class. The continuing application of these academic achievements is in my ongoing role as a Licensed Professional Counselor (TX No. 214889) and as a Licensed Marriage and Family Therapist (TX No. 201142) in this outpatient counseling clinic. Other credentials, memberships, and recognitions received by this therapist include the following: Supervisor/Clinical Member of the American Association of Marriage and Family Therapy (AAMFT); LPC and LMFT Approved Supervisor.

The Counseling Relationship - Individual, marriage, or family therapy is a learning process that seeks for the persons involved to better understand themselves and others as well as the interactions that occur among the participants and significant others. Additional goals include achieving enhanced functioning as an individual, couple, or family so that healthy interactions are established and greater emotional and relational satisfaction is attained.

There are several steps in the therapeutic process. First, time will be spent exploring the nature of the problem(s) that have brought you to therapy. I will need to get to know you, how you view yourself, and the quality of the relationships that you have with others. Obviously, we will need to discuss things openly and honestly. My responsibility at this point in the therapeutic process is to listen to attentively, assist you to communicate with me and others who may be involved, and to provide an environment of trust so that each person can interact freely and speak what is on their mind.

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Areas of Expertise - Complementing my studies in psychology and counseling, I have worked in three separate inpatient-psychiatric facilities emphasizing work with both adolescents and adults. In addition, I have worked with individuals, couples, and families for the past eighteen years in outpatient clinical settings dealing with a wide range of therapeutic issues. Some of these include: Anxiety and Panic Disorders, Depression, Grief, Marital Problems, Family Hostility, Stress, Phobias, Obsessive-Compulsive Disorders, Adult Children of Alcoholics or Dysfunctional Families, Abuse Victims, Post-traumatic Stress Disorder, and various forms of addictive behavior.

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Services Offered and Clients Served - My therapeutic orientation depends on the type of problem being addressed. While I am systemic by training and preference, my approach may draw from any of the following therapies based on the unique needs of the client: Reconciliation-Focused, Solution-Focused Brief, Cognitive-Behavioral, Narrative, Bowenian, Interpersonal, and/or Insight-Oriented therapies. Techniques may involve, at times, visualizations and/or material drawn from spiritual disciplines. In addition, the holistic nature of my views concerning mental health recognizes a person's spirituality as the central organizing principal around which lasting mental health and strong relationships may be achieved. While I make no systematic presentation on the subject, I am decidedly Christian in my orientation.

My counseling work involves working with individuals, couples, and families. When working with individuals in therapy, I often encourage these persons to involve both nuclear and extended family members in the process.

Code of Conduct - You may have questions about me, my qualifications, or anything not addressed in the previous paragraphs. It is your right to have a complete explanation for any of your questions at any time. Please exercise this right. I am required by state law to adhere to a Code of Conduct for Licensed Professional Counselors which is determined by the Texas Licensing Board. A copy of this Code is available on request. Their address and phone number are listed below.

Texas State Board of Examiners of Professional Counselors
Texas Department of State Health Services
Mail Code 1982
P.O. Box 149347
Austin, Texas 78714-9347
P: (512) 834-6658 F: Fax: (512)834-6677

(PLEASE SIGN ON BACK AFTER READING AND RETURN TO THE THERAPIST. RETAIN ONE COPY FOR YOUR USE)

Confidentiality - The communication between you—the client—and your therapist is confidential. This means that you have the privilege to refuse to disclose and to prevent me from disclosing confidential communications made for the purpose of diagnosis or treatment without your written consent (with the following exceptions). Certain exceptions to confidentiality include: If you are a danger to yourself or others; if you have abused or are abusing a child or an adult; if you assert that your mental condition is an issue in a claim or defense as part of civil or criminal law proceedings; if your assessment and/or treatment is court ordered; in proceeding to assist you with entering a hospital for emotional and/or chemical dependency treatment when you and /or your therapist in the course of diagnosis or treatment determine that you are in need of hospitalization; and/or if you seek reimbursement for the cost of your therapy from an HMO, managed care, or insurance company (Your direction that such information be provided does not constitute a waiver of your privilege and I will continue to protect that privilege after providing information to an HMO, managed care or insurance company. I cannot, however, control how such information may be treated by these respective entities. The waiver you sign with your insurance company many make your records available to case management, utilization review and other entities which request your records, such as life insurance companies). I do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law. By signing this document you are acknowledging your awareness and acceptance of such disclosures under these stated circumstances.

When providing couple, family or group treatment, the therapist does not disclose information outside the treatment context without a written authorization form each individual competent to execute a waiver. In the context of couple, family or group treatment, the therapist may not reveal any individual's confidences to others in the client unit without the prior written permission of that individual.

I will use client and/or clinical materials in teaching, writing, consulting, research, and public presentations only if a written waiver has been obtained in accordance with this section, or when appropriate steps have been taken to protect client identity and confidentiality.

I will store, safeguard, and dispose of client records in ways that maintain confidentiality and in accord with applicable laws and professional standards. Subsequent to moving from the area, closing the practice, or upon my death, I will arrange for the storage, transfer or disposal of client records in ways that maintain confidentiality and safeguard the welfare of clients.

Finally, when consulting with colleagues or referral sources, I will not share confidential information that could reasonably lead to the identification of a client, research participant, supervisee, or other person with whom they have a confidential relationship. Information may be shared only to the extent necessary to achieve the purposes of consultation.

Emergency Situation/Absences - If an emergency arises, the client and/or family members are instructed to call 911, go to nearest emergency room, or call the following crisis management hotline at 269-COPE (2673). If I must miss a session(s) due to illness or vacation, I will provide an on-call therapist and/or an emergency contact number to ensure continued client care for possible emergencies.

Client Responsibilities - It is agreed that the client shall make a good-faith effort at personal growth and engage in the counseling process as an important priority at this time in his or her life. Client gain is most important in professional counseling. Suspension, termination, or referral may be initiated by either the counselor or the client. This decision shall be discussed between counselor and client for a pattern of behavior that reveals that the needs of the client would best be served by seeing another specialist, disinterest or lack of commitment to counseling, or for any unresolved conflict or impasse between counselor and client. Clients who come seeking therapy in conjunction with another ongoing professional mental health relationship must first be granted permission by the first therapist for the second to work with the same client. Clients who may wish to terminate the counseling relationship agree to first meet with the therapist before making the final decision. Termination itself can be a constructive, useful process which therefore deserves appropriate attention. Clients coming from another therapist must first terminate with that therapist. Due to an inherent conflict of interest on the part of the therapist who is working with a couple, an individual coming for help resolving relationship problems with a spouse also agrees to refrain from subpoenaing this therapist for testimony in the event that court proceedings develop at a later date.

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Professional Services Contract

_____ (Name(s) of), hereinafter referred to as the Client, has this day retained Asa R. Sphar III, Ph.D. of Counseling Services of Austin, LLC located at 2499 S. Capital of Texas Hwy., Bldg. "A", Suite 200 to provide individual, couple, and/or family therapy.

It is expressly understood that Asa R. Sphar III, Ph.D. has not issued, and will not issue, any guarantee of cure or treatment effects, number of sessions necessary, or total cost of service. It is further understood that Asa R. Sphar III, Ph.D. shall be obligated to maintain a reasonable standard of care for practicing Licensed Professional Counselors and Marriage and Family Therapists. Neither Asa R. Sphar III, Ph.D. nor Counseling Services of Austin, LLC shall be held to any special or elevated standard of care.

We, the undersigned therapist and client, have read, discussed together, and fully understand this agreement and the stated policies. We agree to honor these policies, including the commitment to negotiate and mediate as stated above, and will respect one another's views and differences in their outworking. This agreement is entered into voluntarily by the Client with competency and understanding and knowledge of the consequence.

Client(s) Signature(s) _____ Date _____ / _____ / _____

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Therapist's Signature _____ Date _____ / _____ / _____



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Therapist's Signature _____ Date _____ / _____ / _____

ASA R. SPHAR III, Ph.D., LPC, LMFT

- * - Former Professor of Psychology and Counseling
- * - Director of Counseling Services of Austin, LLC
- * - Licensed Professional Counselor #214889
- * - Licensed Marriage and Family Therapist #201142
- * - Clinical Member / Approved Supervisor – AAMFT

COUNSELING SERVICES OF AUSTIN, LLC

2499 S. Capital of Texas Highway
Bldg. "A"; Suite 200
Austin, TX 78759
P: 512.351.4933
F: 512.301.5559

FEE SHEET

Fees represent my time on your behalf, including record keeping and session preparation.

\$125.00 / 45-50 Minute Therapeutic Hour

- * - All fees are to be paid at the time of service. **Checks should be made payable to Counseling Services of Austin or CSOA.** Health insurance may cover the cost of therapy. An invoice for services rendered will be provided in cases where the client desires to file an insurance claim. It is the responsibility of the client to check for insurance coverage for "outpatient psychotherapy."
- * - Phone calls made after hours will be handled by voice mail and returned on the following day. Since Counseling Services of Austin, LLC provides outpatient diagnostic and psychotherapy services only, we cannot guarantee around-the-clock availability. Therefore, if you should experience an emotional or behavioral crisis and we cannot be reached immediately by telephone, you and your family members are instructed to call 911 or go to your nearest emergency room for assistance (You may call one of the following crisis lines for interim support; 1-800-749-2673 or 1-800-437-0303).
- * - Calls that are returned at the request of the client which pertain to treatment issues will be billed at the rate of \$3.00 per minute (Billed in 15-minute blocks / \$45.00 per block). Long distance calls are returned collect.
- * - Fees for in-home counseling sessions, testing, written treatment summaries, court appearances, consultations, or other special services will be outlined upon request.
- * - Unless otherwise agreed to by the therapist, accounts in arrears over 2 sessions will result in the cessation of therapy until the outstanding balance is made current.
- * - My services are by appointment only. **Because an appointment is reserved for each client, any change or cancellation requires 24 hours notice; otherwise the client will be charged the full fee.** Failure to provide a 24-hour notice of cancellation generally results in the non-availability of the time slot for another individual. The length of the therapy hour is approximately **45-50 minutes**.

(PLEASE KEEP FOR FUTURE REFERENCE)



COUNSELING SERVICES OF AUSTIN, LLC

Extended Information Form

Today's Date _____

Client's Name _____ Age _____ Birth Date _____

Parent/Guardian's Name(s) _____ Age(s) _____

Address _____
street city state zip

Phone (home) _____ (work) _____ (cell) _____ Best Time to Call _____

Marital Status: Single Engaged

Married (how long _____ times married _____)

Separated (how long _____) Divorced (how long _____)

Education _____ Occupation _____ Social Security # _____

Spouse's Name _____ Age _____ Birth Date _____

Spouse's Education _____ Spouse's Occupation _____

List name, birth date, sex, relationship of all children, and whether they live at home with you.

Name	Birth Date	Sex	Relationship	At Home?
------	------------	-----	--------------	----------

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Who is coming for counseling? _____ Any prior counseling? Yes No

If yes, when? _____ Where? _____ With whom? _____

Why? _____

Are you, or another family member, currently seeing a psychiatrist or another counselor? Yes No

If so, what family member? _____ Name of helper _____

For what purpose? _____

Person to contact in emergency (name, relationship, phone, address) _____

PLEASE FILL OUT THE FOLLOWING INFORMATION AS IT APPLIES TO THE CLIENT

State the nature of the problem in your own words: _____

What is your most difficult relationship right now? _____

What is your most difficult emotion right now? _____

CRISIS INFORMATION: Any current suicidal thoughts, feelings, or actions? Yes No
If yes, explain _____

Any current homicidal thoughts or assaultive thoughts or feelings, or anger control problems? Yes No
If yes, explain _____

Any past problems, hospitalizations, or jailing for suicidal or assaultive behavior? Yes No
If yes, explain _____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Yes No
If yes, explain _____

FAMILY BACKGROUND:

Father: First name _____ Age _____ Occupation _____
State of health _____ Resides in _____
If deceased, how and when _____
List three words that best describes him (ex. loving, mean, etc.) _____
How do/did you get along? _____

Mother: First name _____ Age _____ Occupation _____
State of health _____ Resides in _____
If deceased, how and when _____
List three words that best describes her (ex. loving, mean, etc.) _____
How do/did you get along? _____

Stepfather: First name _____ Age _____ Occupation _____
State of health _____ Resides in _____
If deceased, how and when _____
List three words that best describes him (ex. loving, mean, etc.) _____
How do/did you get along? _____

Stepmother: First name _____ Age _____ Occupation _____
State of health _____ Resides in _____
If deceased, how and when _____
List three words that best describes her (ex. loving, mean, etc.) _____
How do/did you get along? _____

Brothers and Sisters: Please list in birth order.

First Name	Age	Where resides	Relationship now		
			Close	Distant	In Between
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your happiest memories of childhood and family are:

Your most unpleasant memories of childhood and your family are:

Have you ever experienced any of the following:

- Harsh physical punishment or abuse as a child
- Sexual advances made toward you as a child
- Sexual abuse
- Incest
- Rape
- Physical by spouse or lover
- Verbal or emotional abuse as a child or adult

If so, please explain:

SUBSTANCE USE/ABUSE HISTORY (N/A if not applicable)

SUBSTANCE	FIRST USE	LAST USE	12-MONTH USE	CURRENT USE
Depressants				
Alcohol	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____
Barbiturates	_____	_____	_____	_____
Hallucinogens				
Marijuana	_____	_____	_____	_____
LSD	_____	_____	_____	_____
Mushrooms	_____	_____	_____	_____
PCP	_____	_____	_____	_____
Stimulants				
Amphetamines	_____	_____	_____	_____
Cocaine (powder)	_____	_____	_____	_____
(crack freebase)	_____	_____	_____	_____
Other _____	_____	_____	_____	_____

MEDICAL INFORMATION:

Current Medical Problems: Please list any current medical problems or symptoms that you are concerned about.

- 1. _____
- 2. _____
- 3. _____

Current Medications: Please give the following information for all prescription or over the counter medications being taken. (Include vitamins, laxatives, diet pills, hormones, birth control, etc.)

NAME	DOSAGE/HOW OFTEN	REASON TAKEN	HOW LONG TAKEN	RESPONSE

Caffeine Usage: Please specify the amount of any of the following products with caffeine that you drink or use in a typical 24 hour day.

- Cola Beverage _____ Brewed Coffee _____ Instant Coffee _____
- Instant Tea _____ Brewed or Sun Tea _____
- Chocolate Beverage _____ Chocolate Candy _____
- Other _____

Surgical History: Please list all surgeries you have had and age at the time of surgery.

- 1. _____
- 2. _____
- 3. _____

Check any of the following that you have had and beside it please indicate when:

- AIDS or a positive AIDS blood test
- Alcohol abuse or alcoholism
- Anemia
- Anxiety disorder
- Asthma
- Cancer, tumor or growth
- Chronic or frequent colds
- Concussion or head injury/trauma
- Depression
- Diabetes
- Drug abuse or addiction
- Eating disorders
- Eye trouble
- Ear, nose or throat trouble
- Epilepsy, seizures, or convulsions
- Fainting spells, feeling light headed or dizzy
- Gambling problem or addiction
- Glaucoma

- Heart trouble
- Headaches that are frequent or severe
- Hepatitis, liver disease, or jaundice
- High blood pressure
- Kidney disease or urinary problems
- Low blood pressure
- Lung disease or respiratory problems
- Manic depression or bipolar disorder
- Migraines
- Mitral valve prolapse
- Mononucleosis
- Panic attacks
- Phobias or severe fears
- Premenstrual Syndrome
- Rheumatic fever
- Schizophrenia
- Sexual addiction
- Sinus or allergy problems
- Stroke
- Stomach or intestinal problems
- Suicide attempt
- Thyroid problem or goiter
- Ulcers
- Venereal disease
- Psychiatric hospitalization (when, how long, reason for admission)

Other mental or emotional problems (please specify)

Please list other medical problems for which you have been treated or hospitalized. Please indicate when and where treated:

Please list any medications that you have taken in the past for anxiety, nervousness, depression or related types of problems.

Name of Medication	When Taken	Degree of helpfulness

Common Problem/Symptom Checklist:

Fill in the blank with the appropriate response related to the severity of each problem in your life:

0 = none 1 = mild 2 = moderate 3 = severe

- | | | | |
|-------------------|------------------------|----------------------|-----------------------|
| ___ Marriage | ___ Divorce/separation | ___ Alcohol/drugs | ___ God/faith |
| ___ Premarital | ___ Child custody | ___ Other addictions | ___ Church/ministry |
| ___ Singleness | ___ Disabled | ___ Grief/loss | ___ Past hurts |
| ___ Sexual issues | ___ Work/ Career | ___ Depression | ___ Codependency |
| ___ Family | ___ School/learning | ___ Fear/anxiety | ___ Intimacy |
| ___ Children | ___ Money/budgeting | ___ Anger control | ___ Communication |
| ___ Parents | ___ Aging/dependency | ___ Loneliness | ___ Self esteem |
| ___ In-laws | ___ Weight control | ___ Mood swings | ___ Stress Management |

Other (specify): _____

RELIGIOUS INFORMATION:

Religious affiliation during childhood and adolescence: _____

Religious affiliation now: _____

Level of meaningfulness of religious affiliation during childhood and adolescence: high medium low

Level of meaningfulness of religious affiliation now: high medium low

Who referred you to us?

Name _____ Relationship _____

Address _____ Phone Number _____

Do you have an objection to us sending a thank you note to the referral source previously mentioned? [] Yes [] No

If no, we will only send a thank you note, any other contact will require your express written permission.

Thank you for taking the time to fill out this information sheet. Your counselor will review this with you in the first session and use it to best assist you in your counseling work. We will maintain your strict confidence regarding this information, subject to the exceptions noted in your service contract (labeled Declaration of Practices and Procedures). Be sure you review and sign the elements of agreement detailed on your service contract.