

Counselor Name: Michael Salas

Highest Level of Education: Master’s Degree of Counseling

License: Licensed Professional Counselor, Licensed Chemical Dependency Counselor

Phone: 214-471-8650

**Informed Consent**

1. Clients will be actively involved in all counseling sessions. The point of counseling is not to solve problems for a client. Instead, it is to assist the client in working through situations themselves. The client will be asked to express what goals they wish to achieve during counseling, and these goals will be the focus of the sessions.
2. **Session focus:** Sessions are focused on the client. Counselor disclosure is solely for rapport and therapeutic change.
3. The counselor cannot guarantee success of a counselor-client relationship. Although the goal is to help clients, the relationship is not always a successful one. The counselor may refer the client to other counseling services.
4. During counseling sessions, clients may discuss topics that are difficult for them to handle. Discussions about support systems will be discussed, but it is the responsibility of the client to utilize these systems.
5. **Limitations to confidentiality.** Client information will be kept confidential except for the following circumstances:
* If a client states that they are going to harm themselves or others, then the counselor is obligated to protect the client and/or the public and will notify the appropriate authorities.
* Counselors may be court-ordered to testify in court. Counselors will ask that they do not have to do this, however they may still be obligated to do so.
* Clients are also expected to disclose their working relationship with another therapist. Should this be discovered during the process of therapy, clients are expected to disclose this information to the other therapist. If they fail to do this, our therapists are obligated to report that another therapeutic relationship has been established.
* If the client reports any abuse of another adult, child, or elderly person, the counselor will be obligated to report this to the appropriate authorities.
* Clients can sign a release of information, should they want information to be released to another entity. A client will have to right to revoke this, but will have to request so in writing.
* Clients who have counselors who have supervisors for Licensure and professional Certification processes may have their cases discussed with these supervisors for case consultation.
* This agency uses case consultation. Cases may be discussed for case consultation with other Vantage Point Counseling clinicians. These discussions are purely clinical in nature. No outside agency consultation is conducted in this setting.
1. **Theoretical Orientation:** Our therapists specialize in the following theoretical orientations:
* Cognitive Behavioral Therapy
* Person-Centered Therapy
* Dialectical Behavioral Therapy
* Gottman Therapy
* Post Induction Therapy
* Eye Movement Desensitization and Reprocessing (EMDR)
* Somatic Experiencing.
1. **Record Keeping:** Counseling and financial records will include all progress notes from each session, demographic and assessment information, consents to release information, and financial and insurance information provided by the client. This office uses Theranest, which is a HIPAA compliant online record keeping resource. After the required timeframe of maintaining such records, records will be destroyed for confidentiality reasons. Should a client want to review his/her own records, this can be done with the counselor present to help explain the information that is being reviewed.
2. **Emergency Services:** In cases of emergencies, clients are expected to call 911 or go their local emergency room.
3. All counseling fees are expected to be paid at the time of service. Insurance benefits are the responsibility of the client to utilize.
4. Vantage Point Counseling Services may adjust fees for service annually. If fees should increase, you will be provided a written notice of two months that this will take place.
5. **Fees:**
* 45-50 minute Individual: $150
* 45-50 minute Evening Session after 6 pm: $225
* Couples Session: $150
* 90 minute session: $260
* Sex Addiction Assessments: $200
* Group Therapy Sessions: $65-75
* For conjoint therapy sessions with two therapists, the individual rate is what is charged.
* Phone conversations are charged in 15 minute increments based on the therapeutic hour.
* No Shows are charged for the full cost of the session that was scheduled.
1. Clients may reschedule appointments via e-mail or text, but clients accept confidentiality risks of such communication.
2. **Intoxication during sessions:** Should you attend your appointment or evaluation intoxicated, and you are unable to participate, you will be charged for the appointment and will be obligated to pay for the next scheduled appointment or evaluation. Your counselor will ask that you call someone for a ride home. If you insist on leaving in your own vehicle, the police will be contacted and given your license plate number for your safety and public safety.
3. Should you participate in couples counseling, and you participate in individual counseling sessions as well as couples sessions and reveal a secret that could impact your relationship, you may be asked to discuss this secret in a counseling session, under the discretion of the professional judgment of your counselor.
4. Disclosure sessions are charged by the hour.
5. Should a client feel that he/she has been overcharged, or that a counselor or counseling intern has not followed the ethical as stated by the Texas State Board of Examiners of Professional Counselors, he/she may file a complaint to:

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
Telephone: (512) 834-6658
Fax: (512)834-6677

1. You may be asked to participate in a random urinalysis test, at the discretion of your counselor.
2. You may be asked to participate in a psychiatric evaluation, based on the judgment of your professional counselor. If you do not have a preferred provider, your counselor will provide you with a referral to one.
3. If you participate in group counseling sessions, I will address the importance of confidentiality, yet I cannot control what group members discuss outside of treatment.

Signing below demonstrates understanding of the information above.

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Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Counselor Signature Date

### Vantage Point Counseling Services

### Michael J. Salas, MA, LPC-S, LCDC

# 3300 Oak Lawn, Suite 415

**Dallas, Texas 75219**

**Tel: 214-471-8650**

# PRE-TREATMENT CLIENT QUESTIONNAIRE

|  |  |  |  |
| --- | --- | --- | --- |
| NAME |  | **TODAY'S DATE** |  |
| **ADDRESS** |  | **DATE OF BIRTH** |  |
| **CITY, ST ZIP** |  | **AGE** |  |
| **PHONE #** |  | **Gender** **Pronoun:** |  |
| **CELL #** |  | **EMPLOYER:** |  |
| **E-mail Address**  |  | **WORK #** |  |
| **INSURANCE:** |  | **License Plate #** |  |

#### Referral Information

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| --- |
| How did you hear about us? |

#### Presenting Problem(s) or Issue(s)

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| --- |
| Why are you here? What is the Number One problem or issue you would like to talk about? |
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| What are your expectations of therapy? |
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#### Family History

|  |  |
| --- | --- |
| **Bio-Father** | **Bio-Mother** |
| **Name** | **Age** | **Occupation** | **Name** | **Age** | **Occupation** |
|  |  |  |  |  |  |
| Physical, mental, or drug alcohol problems? | Physical, mental, or drug alcohol problems? |
|  |  |
|  |  |
|  |  |
| Describe your relationship: | Describe your relationship: |
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| --- | --- |
| **Step-Father** | **Step-Mother** |
| **Name** | **Age** | **Occupation** | **Name** | **Age** | **Occupation** |
|  |  |  |  |  |  |
| Physical, mental, or drug alcohol problems? | Physical, mental, or drug alcohol problems? |
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| --- | --- |
| **Siblings** |  |
| **Name** | **Age** |  | **Physical, mental, or drug alcohol problems?** |
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| Describe your relationship: |  |  |  |
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| Describe your relationship: |  |  |  |
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**RELATIONSHIPS**

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| Describe your current relationship(s) |
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| Please indicate any dates for divorces, separations, etc. |
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| In your relationships, have you been described as “needy” or “controlling”? If yes, describe when: |
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|  |
| In your relationships, have you been described as distant or avoidant? If yes, please explain: |
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| --- |
| Are you currently in more than one relationship? |
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|  |
| If so, is your primary partner aware of this? |
|  |
|  |
| In your relationships, have you been described as “needy” or “controlling”? If yes, describe when: |
|  |
|  |
|  |
| In your relationships, have you been described as distant or avoidant? If yes, please explain: |
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| --- | --- |
| **Children** |  |
| **Name** | **Age** | **Occupation** | **Physical, mental, or drug alcohol problems?** |
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| Who nurtured you when you were growing up? |
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| Who protected you when you were growing up? |
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| What were some of your family rules while growing up? |
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|  |
| How were these rules enforced? |
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#### Social History

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| --- |
| Please describe what it was like for you growing up. Tell me if you moved as a child and any other significant events or happenings of your childhood. |
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| Please describe what it is like for you now where you live. Tell me any moves you’ve made as an adult and any other significant events or happenings of your adult life so far. |
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| How do you confront someone who you have an issue with? |
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| How do you handle it when someone confronts or criticizes you? |
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#### Academic, Intellectual and Vocational History

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| --- |
| How far in school have you gone? |
| What was the name and location of your High School? Year Graduated? |
| What kind of a student were you? |
| Where you in any special education programs? |

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| --- |
| If you attended college, Please tell me where, when you graduated, and what your major area of study was. |
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| Where do you currently work?  |
|  |
| What do you consider your occupation, trade or position there? |
|  |
| Please list your three longest held jobs, dates and position held. |
| 1. Dates: Position: |
| 2. Dates: Position: |
| 3. Dates: Position: |
|  |
| Do you have any problems with employment at this time? (i.e. Overworked, underemployed, too high stress) |
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#### Medical/Developmental History

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| --- |
| Did you have any birth trauma, childhood injuries, hospitalizations or anything else that was “unusual”? Please explain: |
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| Do you currently have any medical conditions? If yes, explain: |
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| Do you deal with chronic pain? If so, please describe: |
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| What medications are you currently taking? |
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| Who is your Primary Care Physician? |

#### Mental Health History

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| Have you ever been hospitalized for any mental health condition? Please explain. |
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| Do you currently have any mental health conditions? If yes, explain: |
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| What medications are you currently taking? |
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| Who prescribes these medications? |
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| Have you had mental health counseling in the past? If yes, please tell me when and with whom. |
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| What is the worst thing that has happened to you? |
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| Do you find it difficult to pay attention or focus? |
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| What fears do you have? |
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**Substance Abuse History/Addiction History**

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| --- | --- | --- | --- | --- | --- | --- |
| **Substance** | **Age of 1st Use** | **Age of Regular Use** | **Amount** | **Frequency** | **Maximum Use** | **Last Used** |
| Alcohol |  |  |  |  |  |  |
| Tobacco |  |  |  |  |  |  |
| Cannabis |  |  |  |  |  |  |
| Meth |  |  |  |  |  |  |
|  Amphetamine |  |  |  |  |  |  |
| Heroine |  |  |  |  |  |  |
| Opiods (painkillers) |  |  |  |  |  |  |
| Benzodiazepines (Xanax, Ativan) |  |  |  |  |  |  |
| Hallucinogens  |  |  |  |  |  |  |
| Inhalants  |  |  |  |  |  |  |

**Consequences of Substance Abuse (Circle What Applies):**

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| Have you ever had any counseling or treatment for drug or alcohol use? If yes, please list when and where and if you completed the treatment. |
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| Do you gamble (pickle cards, lottery, casino, other)? If yes, explain |
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| Do you believe you have any problems with internet, shopping, food, sex, porn or other addictive/compulsive behaviors? |
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| Do you have any sexual concerns/issues that you would like to discuss? |
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| Do you view pornography or have any issues with compulsive masturbation? |
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| Have you had any affairs outside of your primary relationship? |
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| Do you regularly attend strip clubs, adult book stores etc.? |
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| Has anyone ever complained or been worried about your sexual behavior? |
|  |
| Ever been treated for process addictions? |
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#### Trauma History

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| List accidents that you have been in: |
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| Do you have a history of head trauma? Please explain: |
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| Have you suffered from a physical attack from a person or animal? Please explain: |
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| Any other traumas that you did not list above? |
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**Sexual Issues**

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| Do you have problems with low sexual desire? |
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| Are you having pain with sex? Please describe: |
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|  |
| Are you struggling with problems with orgasm? |
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|  |
| Do you struggle with maintaining an erection? |
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|  |
| Any other issues relating to sex, sexuality, sexual orientation, or gender expression not previously mentioned: |
|  |

#### Legal /Offender History

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| --- |
| Have you ever been arrested? If yes, please explain giving dates, charges, and outcome. |
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#### Victim Issues

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| Have you ever been the victim of physical, emotional or sexual abuse? If yes, please explain. |
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#### Personal Assets and Liabilities

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| --- |
| What do you consider your strengths/assets? List up to three: |
| 1). |
| 2). |
| 3). |
| What do you consider as your weaknesses/liabilities? List up to three: |
| 1). |
| 2). |
| 3). |

#### Other Issues

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| Is there anything else you would like to share with me? |
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|  |
|  |

 **Your Goals for Evaluation or Counseling**

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| --- |
| 1. |
|  |
| 2. |

### Vantage Point Counseling Services.jpg

# 3300 Oak Lawn, Suite 415

**Dallas, Texas 75219**

Credit Card Authorization Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Vantage Point Counseling Services to charge my credit card for each counseling session.

I understand it is my responsibility to keep an updated copy of my credit card information on file. If my credit card is declined for any reason, I am responsible for immediate payment of the full balance by cash or check. I also understand, as per the informed consent that I signed, that my card may be charged for each session that I fail to give a 24 hour notice of my inability to attend.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

Name as it appears on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Mastercard ☐ Visa ☐ American Express ☐ Discover

Credit Card #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CCV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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