LIBERTY ALLIANCE GROUP

Dr. Mark Jones, LMFT Nancy Sheridan, CRT Dub Jones, CRT

By providing this information you are agreeing to be added to our **confidential database**, which we will only use to contact you regarding appointments, upcoming seminars and events.

Name_____

Spouse _____

Address_____

_____

Best phone # to contact you_____

Your email _____Spouse Email_____

Please "Like" **Trinity Program** on Facebook for ministry news and updates

DR. MARK JONES, LMFT, D.MIN

Licensed Marriage & Family Therapist

INTAKE FORM

TODAY'S DATE	

SECTION I - CLIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE	DATE OF BIRTH
E-MAIL ADDRESS			AGE
STREET ADDRESS		APT #	
CITY	STATE	ZIP CODE	
HOME PHONE	WORK PHONE	CELL PHONE	
MARRITAL STATUS *(circle one)*	MARRIAGE *(circle one)*	HOW LONG MARRIED	
Single *(never married)* / Married Divorced / Separated / Widowed	1st 2nd 3rd 4th 5th	SPOUSES NAME	
HOW DID YOU HEAR ABOUT US?			

SECTION II - WORK OR SCHOOL INFORMATION

EMPLOYER NAME OR NAME OF SCHOOL	OCCUPATION OR GRADE
JOB TITLE	HOW LONG EMPLYED (currently)

SECTION III - FAMILY INFORMATION

LIST THE NAMES AND AGES OF YOUR CHILDREN *(if minors please list their date of birth)*

Name	Age or DOB *(if minor)*	Name	Age or DOB *(if minor)*
Name	Age or DOB *(if minor)*	Name	Age or DOB *(if minor)*
Name	Age or DOB *(if minor)*	Name	Age or DOB *(if minor)*
YOUR FATHERS NAME	LIVING OR DECEASED?	YOU MOTHERS NAME	LIVING OR DECEASED?

Names of other Family Members seen here:

SECTION IV - MEDICAL INFORMATION

List all current Medications, Vitamins, Supplements you are taking at this time:

Reasons for medications:

Name of Current Counselor, Therapist, Medical Doctor you are currently under the care of:

Previous Counseling History (when and for how long)

SECTION V - EMERGENCY CONTACT INFORMATION

Name of local friend or relative

HOME PHONE		CELL PHONE	
Relationship to you			

INFORMED CONSENT FORM

As a client, you have certain rights that are important for you to understand.

This document is designed to inform you about the management of information that you disclose to your therapist/counselor. Therapy addresses issues of a highly personal nature and it is important for the success of treatment that you have confidence in your therapist/counselor's ability to manage your records responsibly. Also provided is a detailed description of our fees, and cancellation policy.

Purpose of Collecting and Retaining Information

As part of providing service to you, your therapist/counselor will need to collect and record personal information that is relevant in your assessment, diagnosis and treatment. The information retained will document what happens during sessions, and enables the therapist/counselor to provide you with informed counseling and treatment plans.

Confidentiality

With the exception of certain specific exceptions described below, you have the right to confidentiality of your information. You are assured that all personal information gathered by the therapist/counselor during your session will remain confidential and secure in our office.

However, it is important to know that there are exceptions in which all therapist/counselors are mandated (by law) to break confidentiality. This can occur when:

1. The information you have given to your therapist/counselor is subpoenaed (officially requested) by a court of law
2. Failure to disclose the information would place you or another person at serious risk of harm
3. Your prior approval has been obtained to
   a) provide a written report to another professional or agency, eg. a lawyer; or
   b) discuss the material with another person, eg. a parent or employer

Accessing your Client Information

All communications between you and your therapist/counselor become part of our records, which are stored in your client file. Client files are held in a secure filing cabinet, or digital secure storage

A client has a general right of access to all information in their file, unless one of the exceptions below restrict access where:

- giving access would pose a serious threat to the physical or mental health of any individual

- giving access would jeopardize the privacy of others
- giving access would hinder any law enforcement activities

Diagnostic/Personality Testing

A Diagnostic Test and a Personality Profile Test will be given to all new clients for assessment purposes. these are beneficial to the therapist/counselor's care and treatment plan for each client.

Fees

We are a private pay office, with the exception of clients seeing Gene Benedict, LPC who also accepts Tricare

Please pay all fees by credit card, cash or checks payable to South Texas LAG

Dr. Jones, LMFT rate is $185 per hour

Gene Benedict, LPC and Caroline Gaines Behrens, Certified Life Coach fees are $130 per hour

Dub Jones, Brittany Dodson and Nancy Sheridan, CRT (Certified Restorative Therapists), rates are $95 an hour

A one-time $30 Diagnostic Test and Personality Profile is given to all new clients.

*You may be able to claim private health insurance reimbursement for a portion of the fees you have paid our licensed counselors and therapists depending on your benefits plan. Upon your request, we can supply a 1500 form to submit to your insurance. We charge a nominal fee of $10 per form with 3 sessions on each form. We do not guarantee reimbursement by your insurance provider, please check with your Benefits Department. Please give at least 3 business days return time on 1500 form requests- WE CANNOT PROVIDE SAME DAY REQUESTS. We can expedite by emailing you the completed form at your request.

Cancellation Policy

If, for any reason you need to cancel or postpone the appointment, please give our office at least 24 hours' notice. We charge a missed appointment fee of $45.00 at the time of cancellation without a 24-hour notice.

Confirmation of Informed Consent

I, (*print name in Block Capitals*)..... have read and understood the above Consent Form.

By signing this form, I agree I am responsible for the fees and agree to the conditions set forth by *South Texas Liberty Alliance Group*. I give my consent to complete the Diagnostic Testing as recommended by my therapist/counselor to include a Personality Profile Assessment and scoring administered by employees of *South Texas Liberty Alliance Group, Inc.* I also understand that I am responsible to pay all session fees, any materials purchased, and Diagnostic Testing fees at the time of service.

Signature ..... Date .....

*If client is under 18 years of age

Parent/Guardian Signature ..... Date .....