



CLIENT INFORMATION

7465 W. Lake Mead Blvd., Ste. 100 • Las Vegas, NV 89128
702.480.4891 (Chad) • 702.480.4834 (Pam) • 702.562.1221 (Fax)

Date: _____

Personal Information:

Name: _____

Age: _____ Date of Birth: _____

Address (primary): _____

_____	_____	_____
City	State	Zip

- Who may we thank for this referral? _____

Contact information:

Please list the numbers where we may contact you.

Home: _____ May a message be left at this number? Yes No

Cell: _____ May a message be left at this number? Yes No

Work: _____ May a message be left at this number? Yes No

Email : _____

Background Information

Highest grade level completed: _____ Special Ed: Yes No

Marital status: Single Married Living with significant other
 Divorced Separated Widowed

Length of current significant relationship/marriage: _____

Number of Children: _____ Ages: _____

Identified Race:

African American Asian Caucasian Hispanic Native American Other: _____

Religion:

Baptist Catholic LDS Lutheran Jewish Protestant None Other: _____

Other Household Members:

Name	Age	Relationship to you

If Client is a Minor:

Parent/Legal Guardian's Name(s): _____

Address (primary): _____

City State Zip

What concerns bring you to counseling at this time?

1. _____
2. _____
3. _____

What would you like to gain from counseling?

1. _____
2. _____
3. _____



CONSENT TO TREATMENT & OFFICE POLICY STATEMENT

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Treatment

Treatment will include evaluation, history taking, testing when recommended, assignments for therapeutic goal achievement, treatment planning and consultations. You are expected to play an active role in your treatment. Your progress in therapy may depend much more on what you do between sessions than on what happens in your sessions.

If you and/or I believe that a referral to another professional would be appropriate during the course of our treatment, you will be given referrals for other community agencies and/or private mental health practitioners who may better meet your needs. Treatment is most often terminated by mutual agreement. You may discontinue treatment at any time by notifying me.

Medical issues (e.g., medications or diagnoses) may be discussed during your sessions; however, it should be noted that your counselor is NOT a medical doctor, and that any such discussions pertinent to your medical care should be directed to your physician.

We do not conduct assessments for children with pending custody proceedings.

Appointments

You may call 702.480.4891 (Chad) or 702.480.4834 (Pam) to schedule, reschedule, or cancel an appointment. Sessions that are not cancelled 24 hours prior to your scheduled appointment will be assessed a **\$50.00 cancellation/no-show fee**. If you miss two or more consecutive appointments, your session time will be made available for another client.

Fees

Fees are due in full each session. **All sessions are a 50-minute hour unless otherwise noted.** The following is our list of fees:

Service	Fee
Psychotherapy initial assessment and diagnostic interview	\$125.00
Individual counseling (50 minutes)	\$100.00
Individual counseling (25 minutes)	\$50.00
Couples/Marriage/Family counseling (50 minutes)	\$120.00
Couples/Marriage/Family counseling (25 minutes)	\$60.00
Substance use assessment interview and Nevada evaluation report completion (<i>excluding chemical testing</i>)	\$125.00
Substance use assessment computerized testing	\$25.00
Substance abuse chemical testing	
♦ Urinalysis (10-panel drug + adulterants)	\$25.00 (UA)
♦ Breathalyzer (Volatilized blood-alcohol content)	\$10.00 (BAC)
Clinical supervision (small group)	\$40.00
Clinical supervision (Individual, by appointment)	\$60.00
Telephone consultation (per 15 minutes)	\$25.00
No-show/Last-minute (less than 24 hours) cancellation fee	\$50.00
Professional Consultation	\$100.00
Outside consultation (e.g., attorney, court, school, etc.)	\$350/hour

It is your responsibility to pay for any services received before you terminate your treatment.

Confidentiality (Privacy of Information)

A record of all evaluation and treatment sessions is kept. This information is confidential. Information about your treatment cannot be shared with anyone (e.g., insurance companies, attorneys, physicians, family members, and others) without your written consent. However, certain laws and ethical standards limit confidentiality of treatment information.

Limits of confidentiality are as follows:

- Signed Release of Information form
- Suspected incidents of child or elder abuse
- Potential danger to self or others
- Breach of contract (small claims court)
- If you are a minor, information can be released to the parent(s)/legal guardian(s); however, limits of this release will be discussed concurrently with the parent(s)/guardian(s) and the minor.
- Periodic consultation with supervisors

Risks/Benefits

Therapy has been demonstrated to help many individuals. Therapy is most effective when you follow through on any "homework" assignments or any other activities that we agree might be helpful. One of the primary risks of therapy is the fact that change sometimes comes quickly and easily, but most often is slow and frustrating. Another risk of therapy is that the process may include discussing problems or events that may evoke unpleasant feelings. If this occurs, please inform me immediately so that these feelings may be addressed in a timely and appropriate manner.

Emergencies

In the case of an emergency, a session will be scheduled as soon as possible if needed. If you have an emergency that occurs after regular business hours, you may call 911 or Montevista, a psychiatric facility that provides 24-hour crisis assistance (702.364.1111).

The Therapeutic Relationship

As a professional we will use our best knowledge and skills to help you. Additionally, we must abide by the rules and standards set forth by our professional licensing and certification Boards. In your best interests, these Boards put limits on the relationship between a therapist and a client, and we will abide by these limits.

My signature below indicates that I have read and understand the nature and limits of the services provided. I agree to voluntarily participate in therapy services and will aid in the formation and completion of a treatment plan.

Note: If client is under the age of 18 years, a parent or legal guardian must sign in addition to the client.

Client Signature

Date

Parent/Guardian Signature (if required)

Date

_____ Date _____ Date
 Chad L. Cross, PhD, MS Pamela B. Cross, MS
 NCC, MAC, SAP, CCH, LCADC, MFT NCC, MFT

<p>Licenses and Certifications for Chad L. Cross, PhD, MS <i>MS: Counseling (University of Nevada Las Vegas)</i> <i>PhD: Statistics/Quantitative Ecology (Old Dominion University)</i> NPI: 1477769438</p> <ul style="list-style-type: none"> • National Certified Counselor (NBCC: 87287) • Master Addictions Counselor (NBCC: 87287) • Substance Abuse Professional (NADAAC: 80855) • Licensed Clinical Alcohol & Drug Counselor (NV: 125-LC) • Licensed Clinical Alcohol & Drug Counselor Supervisor (NV: 8-LCS) • Licensed Marriage & Family Therapist (NV: 1117) <p>Licenses and Certifications for Pamela B. Cross, MS <i>BS: Psychology (University of Nevada Las Vegas)</i> <i>MS: Counseling (University of Nevada Las Vegas)</i> NPI: 1275749236</p> <ul style="list-style-type: none"> • National Certified Counselor (NBCC: 87289) • Licensed Marriage & Family Therapist (NV: 1150)
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Please initial the appropriate box:

	Yes , I would like a copy of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Information.
	No , I would <u>not</u> like a copy of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Information.



CREDIT CARD AUTHORIZATION FORM

7465 W. Lake Mead Blvd., Ste. 100 • Las Vegas, NV 89128
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I, _____, hereby authorize **Crossroads Wellness, LLC** to charge my credit card for:

<input checked="" type="checkbox"/> REQUIRED	No-show/Last minute cancellations (less than 24 hours prior to scheduled appointment time)
<input type="checkbox"/> OPTIONAL	Each session as long as therapy continues
<input type="checkbox"/> OPTIONAL	Substance abuse tests (Urinalysis and/or Breathalyzer)
<input type="checkbox"/> OPTIONAL	Any outstanding account balance not paid after a month of due date

Credit Card Information

Visa Mastercard

Credit card number: _____ - _____ - _____ - _____

CVV2 Code (Security Code on Back of Card): _____

Expiration date: ____ / _____

Client information

Name as it appears on the card:	
Billing address:	
City, State, Zip:	
Phone number:	()

My signature below indicates that I voluntarily participate in therapy services and will be responsible for payments and any account balance before I terminate treatment.

_____ Client Signature

_____ Date

 Chad L. Cross, PhD
 NCC, MAC, SAP, CCH, LCADC, MFT

_____ Date

 Pamela B. Cross, MS
 NCC, MFT

_____ Date



CROSSROADS WELLNESS, LLC

BRIEF MEDICAL & MENTAL HEALTH HISTORY

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Please check all that apply.

Current <i>(within the last month)</i>	Past	Depression checklist
		Insomnia
		Low energy/interest/activity
		Low/high appetite and/or weight gain/loss
		Low self-esteem and/or irrational guilt
		Withdrawal/tearfulness/despair
		Poor concentration/memory
		Suicidal thoughts, attempts, and/or plans
		Hopelessness/helplessness

Current <i>(within the last month)</i>	Past	Anxiety and related disorders checklist
		Anxiety/panic attacks: Sudden onset lasting _____ minutes
		Physical symptoms: Can't catch breath and/or heart pounding
		Nausea/numbness/shaky/sweating/flushing/tingling
		Sense of doom/escape/avoidance of public places
		Anxiety triggered by:
		Sleep: Nightmares/restless/bedwetting
		Flashbacks/depersonalization
		Obsessions/compulsions/invasive thoughts
		Rituals/routines/perfectionism/tics/twitches
		Pains in chest/head/stomach
		Clinging/shyness/irrational fears
		Binging/purging/distorted body image
		Sexual problems
		Mania: Sleeplessness/spending/grandiosity/taking risks
		High energy/hostility/offensiveness/irrationality
		Bizarre behavior/hallucinations/delusions
		Social deterioration/fearlessness

Current <i>(within the last month)</i>	Past	Attention and behavior difficulties checklist
		Inattentive: at all times/when bored
		Restless/fidgets
		Impulsive/distractable
		Interactive problems: Fighting/provocation
		Aggression: Physical/verbal/animals
		Destructive: Self/others/things: Own/others
		Injuries: Self/others/use of weapons
		Trouble with authority, with friends, with gangs, alone
		Trouble waiting/rude/defiant/vindictive/holds grudges
		Tantrums lasting _____ minutes/hours caused by frustration (or other causes: _____)

Current <i>(within the last month)</i>	Past	Neurological checklist
		Loss of responsiveness/awareness
		Loss of bladder or bowel control
		Headaches/aura/sensory hallucinations/fits
		Difficulty writing/hyper-moralistic/blinking
		Visual distortions/amnesia/inconsistent personality
		Blackouts/concussions/delirium tremens/loss of consciousness

Counseling/Psychological History

	YES	NO
Are you currently in counseling or under psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever participated in psychological counseling?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Individual counseling?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Couple/marriage counseling?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Group counseling?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever participated in addictions counseling?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Alcohol counseling?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Drug counseling?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Gambling counseling?	<input type="checkbox"/>	<input type="checkbox"/>

Medications

Current Prescription Medications	Dosage	Prescribing Physician

Current Non-prescription/Over-the-counter medications	How long have you been taking these medications?