CONNECTED
LIFE COUNSELING
A PLACE FOR RELATIONAL WELLBEING

6280 McLeod Drv, Suite 120-A
Las Vegas, NV 89120
(702) 853-5031

Welcome!

I am honored you have chosen Connected Life Counseling Center as your choice for relational well-being. It is our mission to help people become more connected to themselves, others, and God.

As a licensed Marriage and Family Therapist, my goal is to focus our time together on systems therapy. Systems therapy works with relationships and cycles of interactions between people. During our sessions, we will delve into areas in your life that may be affecting your relationships and interactions with others.

Connected Life Counseling Center is a place where families, individuals, and couples can get one-on-one therapy, attend groups, and take classes. A common thread in all of our services is focusing care around increasing self-worth, creating effective self-talk, and setting up healthy boundaries. Overall, as a member of our Center, you will learn how to renew your mind through the identification of how your thoughts affect your feelings and behavior.

Our time together will be directly tied to goals we set in our initial sessions and ongoing re-evaluations. Our promise to each client is to work within the framework of “brief therapy” thus, goals are usually met within eight to ten weeks, allowing room for new goals to be set. It is important to understand that the success of therapy does not just depend on the work we do together, but also in day-to-day life. A large part of our process includes assignments outside of the Center. Over time, you will see your relationships and quality of life improve.

We work hard to make your experience transformative, fun, and life-changing.

I look for to the privilege and opportunity to work with you,

Betty Rae Koebcke

Betty Rae Koebcke, M.A., LMFT

NEW PATIENT INTAKE FORM – CLIENT 1

Name: _____ Sex: □ M □ F

Age: _____ Date of Birth: _____ Referred by: _____

Address: _____Apt #: _____

City: _____ State_____ Zip: _____

Home Phone: _____ Cell Phone: _____

Okay to leave messages on the numbers listed: □ Yes □ No Best time to contact: □ AM □ PM

Name of Parent or Legal Guardian (If under 18) _____

Current Marital Status (Parent's status if minor):

□ Single □ Married □ Separated □ Divorced □ Remarried □ Widowed

Have you ever been separated? □ Yes □ No Length of Separation: _____

Have you ever filed for divorce? □ Yes □ No Date Filed: _____

If married, please fill out the below. If not, please skip to next question.

Spouse Name_____ Date of Marriage: _____

Sex: □ M □ F Age: _____ Date of Birth: _____

Do you have children? □ Yes □ No

If yes, please list their name, age, gender, and if they are currently living with you.
If no, please skip to next question.

Name	Age	Gender	Residing (Yes/No)

In case of an emergency, contact:

Name: _____

Contact Number: _____ Relationship: _____

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NEW PATIENT INTAKE FORM – CLIENT 1

Therapy Information:
Describe your current functioning level by circling one of the following to indicate how well you are coping at the present time. 100% means that you are coping the best that you can considering your situation

0% − 10% − 20% − 30% − 40% − 50% − 60% − 70% − 80% − 90% − 100%

Describe any problems that affect your daily functioning. For example: job, relationship, sleep, ability to care for yourself or your children, etc.

_____

_____

_____

_____

Problem Checklist (Please check all that apply)

- ☐ Abused as a Child
- ☐ Addiction(s)
- ☐ Anger/Bitterness
- ☐ Anxiety or Panic Attacks
- ☐ Apathy
- ☐ A Vice
- ☐ Blended Family Issues
- ☐ Change in Lifestyle
- ☐ Children
- ☐ Control Issues
- ☐ Communication Issues
- ☐ Depression
- ☐ Divorce Issues
- ☐ Eating Disorders
- ☐ Employment Issues
- ☐ Fear
- ☐ Financial Troubles
- ☐ Gambling
- ☐ Gluttony
- ☐ Grief/Loss
- ☐ Guilt/Shame
- ☐ Health Problems
- ☐ Infertility
- ☐ In-law/Parent Problems
- ☐ Life Transition Problems
- ☐ Low Self-Esteem
- ☐ Marital Trouble
- ☐ Memory Problems
- ☐ Mood Swings
- ☐ Parent-Child Conflict
- ☐ Post-Abortion Trauma
- ☐ Rebellious
- ☐ Same-Sex Preference
- ☐ Sexual Troubles
- ☐ Sexual Abuse (child or adult)
- ☐ Sleep Troubles
- ☐ Spiritual Problem
- ☐ Spousal Conflicts
- ☐ Suicidal Thoughts or Actions
- ☐ Unresolved Conflicts
- ☐ Violence in the Home
- ☐ Work Problems

_____

_____

Social Network:
Religious Affiliation if any: _____ Church Affiliation: _____

Attend any services ☐ Yes ☐ No How often? _____

What best describes current relationships you have with friends (check one)?
☐ I have several strong friendships ☐ I have a few close friends ☐ I have no friendships

What describes current relationships with family (check one)?
☐ I am close and feel support with family
☐ I am close to some family but others are a great source of frustration or stress
☐ I have no family close by
☐ I have family close by but they are a source of great tension and anger

NEW PATIENT INTAKE FORM – CLIENT 2

Name: _____ Sex: □ M □ F

Age: _____ Date of Birth: _____ Referred by: _____

Address: _____Apt #: _____

City: _____ State_____ Zip: _____

Home Phone: _____ Cell Phone: _____

Okay to leave messages on the numbers listed: □ Yes □ No Best time to contact: □ AM □ PM

Name of Parent or Legal Guardian (If under 18) _____

Current Marital Status (Parent's status if minor):

□ Single □ Married □ Separated □ Divorced □ Remarried □ Widowed

Have you ever been separated? □ Yes □ No Length of Separation: _____

Have you ever filed for divorce? □ Yes □ No Date Filed: _____

If married, please fill out the below. If not, please skip to next question.

Spouse Name_____ Date of Marriage: _____

Sex: □ M □ F Age: _____ Date of Birth: _____

Do you have children? □ Yes □ No

If yes, please list their name, age, gender, and if they are currently living with you.
If no, please skip to next question.

Name	Age	Gender	Residing (Yes/No)

In case of an emergency, contact:

Name: _____

Contact Number: _____ Relationship: _____

NEW PATIENT INTAKE FORM – CLIENT 2

Therapy Information:
Describe your current functioning level by circling one of the following to indicate how well you are coping at the present time. 100% means that you are coping the best that you can considering your situation.

0% − 10% − 20% − 30% − 40% − 50% − 60% − 70% − 80% − 90% − 100%

Describe any problems that affect your daily functioning. For example: job, relationship, sleep, ability to care for yourself or your children, etc.

_____

_____

_____

_____

Problem Checklist (Please check all that apply)

- ☐ Abused as a Child
- ☐ Addiction(s)
- ☐ Anger/Bitterness
- ☐ Anxiety or Panic Attacks
- ☐ Apathy
- ☐ A Vice
- ☐ Blended Family Issues
- ☐ Change in Lifestyle
- ☐ Children
- ☐ Control Issues
- ☐ Communication Issues
- ☐ Depression
- ☐ Divorce Issues
- ☐ Eating Disorders
- ☐ Employment Issues
- ☐ Fear
- ☐ Financial Troubles
- ☐ Gambling
- ☐ Gluttony
- ☐ Grief/Loss
- ☐ Guilt/Shame
- ☐ Health Problems
- ☐ Infertility
- ☐ In-law/Parent Problems
- ☐ Life Transition Problems
- ☐ Low Self-Esteem
- ☐ Marital Trouble
- ☐ Memory Problems
- ☐ Mood Swings
- ☐ Parent-Child Conflict
- ☐ Post-Abortion Trauma
- ☐ Rebellious
- ☐ Same-Sex Preference
- ☐ Sexual Troubles
- ☐ Sexual Abuse (child or adult)
- ☐ Sleep Troubles
- ☐ Spiritual Problem
- ☐ Spousal Conflicts
- ☐ Suicidal Thoughts or Actions
- ☐ Unresolved Conflicts
- ☐ Violence in the Home
- ☐ Work Problems

Social Network:
Religious Affiliation if any: _____ Church Affiliation: _____

Attend any services ☐ Yes ☐ No How often? _____

What best describes current relationships you have with friends (check one)?
☐ I have several strong friendships ☐ I have a few close friends ☐ I have no friendships

What describes current relationships with family (check one)?
☐ I am close and feel support with family
☐ I am close to some family but others are a great source of frustration or stress
☐ I have no family close by
☐ I have family close by but they are a source of great tension and anger

IMPORTANT INFORMATION FOR CLIENTS

Appointments and Scheduling
All appointments will be scheduled by myself, Betty Rae, or with my staff, either in person at the office or by calling directly. To ensure our time together is secured, I recommend setting up a series of appointments to begin as soon as my schedule permits. Ask about our care plan options today to find out how to effectively manage our time together.
This is not a crisis center. Our phones are answered Monday through Friday during business hours. If you are experiencing a psychiatric emergency or crisis, please call 911 or the Crisis Connection (866) 379-6363.

Cancellation Policy
Your appointment time has been reserved for you because your time is valuable. Sessions must be cancelled 24 hours in advance. There will be a $50.00 cancellation fee assessed for short notice or if no cancellation notice is received. If you are unable to reach myself or my staff, please leave a message, we will listen to your message privately and respond to it confidentially and within 24-48 hours. ***The cancellation fee policy is strictly enforced.***

Counseling Rates
My base rate is $120.00 per hour; however, limited slots are available. If you are experiencing financial hardship, and a slot is available, rates may be reduced. For more information, please discuss this with me. Payment is due for sessions at the time of service. I accept credit card, check, and cash – but prefer cash or check to eliminate the credit/debit card fee.

Confidentiality
All of our sessions and phone conversations will be confidential unless the following exceptions apply: (1) You sign a Consent for Release of Information Form authorizing me to communicate information about you with one or more specified professionals or agencies outside of our office; (2) Your records are subpoenaed by a court, although as a therapist I do not agree to testify in legal matters related to or unrelated to therapy; (3) You are a minor under 18 and you parents can access your records unless you are emancipated, pregnant, or in danger of harm from one or both of your parents; (4) You have had inappropriate contact with a health care provide and their name is provided which would be mandated to be reported to their licensing board; (5) I have reason to suspect child abuse or endangerment of a vulnerable adult; and/or (6) you are in imminent danger of harming yourself or another person. You can view the AAMFT code of ethics by going to their web site at www.aamft.org.

Confidentiality for Couples and Family Counseling:
Please be advised that in couples counseling no secrets are kept, therefore anything you tell your therapist individually is part of the couple's records. Additionally, no party shall attempt to subpoena my testimony or request their records be presented in a deposition or court hearing of any kind, such as a divorce case. Both parties agree the goal of counseling is to improve relational distress and the process of therapy depends on trust and openness during sessions. All marriage and family therapy services in Nevada are regulated by the Nevada Board of Marriage and Family Therapist Examiners. Questions or complaints may be addressed to P.O. Box 72758, Las Vegas, Nevada, 89170. The phone number is (702) 486-7388.

Initials _____ *Initials* _____

INFORMED CONSENT

Dual Relationships
My professional code of AAMFT ethics and the Nevada statutes are very strict in terms of dual

relationships. Due to this ethical code, our relationship is strictly therapist-client based.

Communication

Please only use voicemail or emails for information regarding appointment scheduling. Please do not email information related to your session as email is not completely secure or confidential. Please do not use SMS (texting), Twitter, Facebook, LinkedIn, or other Social media sites to contact us. These sites are not secure. Any friend requests or connection requests from current or former clients will not be accepted. If you have any questions, please ask.

Your rights as a family therapy consumer are:

1. To receive information concerning the methods of therapy employed the techniques used, the duration of therapy (if known) and the fee structure for services provided.
2. To seek a second opinion. If needed, I can provide you with names of other qualified professionals.
3. To terminate therapy at any time without any moral, legal or financial obligations other than those already accrued.
4. To know that in a professional psychotherapeutic relationship sexual intimacy between therapist and client is never appropriate.
5. To know our therapeutic relationship is confidential except under the following conditions:
    a. If you threaten bodily harm or death to yourself or another person.
    b. If you reveal information about physical abuse, sexual abuse or neglect in regards to a child or elderly person.
    c. If you are in court-ordered therapy.
    d. If a court of law issues a legitimate subpoena or a judge breaks your confidentiality,
    e. If you are under age 18 in the State of Nevada, parents have access to information in regards to their child's medical records.

Initials _____ *Initials* _____

AGREEMENT

1. I have read and understand the above policies.
2. I have read and understand the financial obligations and cancellation policies.
3. I have been informed of my therapist's credentials and my rights as a client.

_____ _____
Client 1 Signature Date

_____ _____
Client 2 Signature Date

_____ _____
Betty Rae Koebcke, MFT Date