

ALLEN COUNSELING ASSOCIATES

1506 N. Greenville Ave, Suite 220
Allen, Texas 75002
214-509-6888

N Appt	_____
Pmt	_____

CLIENT INFORMATION

Name _____ Date _____

Address _____ City _____ Zip Code _____

Phone #'s: HM _____ WK _____ Mbl _____ message OK?

E-Mail Address _____ Check if OK to send email. # of Children _____

Marital Status _____ Age _____ Birthday ____/____/____

Employment _____ Social Security Number _____

Emergency Notification _____

Name	Relationship	Phone
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Person Responsible for Payment _____

Phone Number: _____ Address: _____

Employer _____ **Authorization #** _____

Insured's Name _____ Relationship to Insured _____

Insured's SS# _____ Insured's DOB: _____

DL # _____ Referred by: _____

**** If you have your insurance card, I will make a copy and you can skip the lines below****

Insurance Name/Address _____

Phone Number _____ Policy/Group Number _____

I hereby give the office Allen Counseling Associates and their staff permission to file any claims and exchange any information necessary to receive payment for services performed.

Signature Date

Signature Date

The information of the following intake form is crucially important in making the correct decisions in the direction of treatment. Please answer the following questions as completely as possible ignoring those that do not pertain to your life situation.

What is your chief concern at this time? _____

What stressful events have recently occurred? _____

Please check any current symptoms you are experiencing.

- | | | |
|--|---|--|
| <input type="checkbox"/> Decreased Energy | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Intrusive/Negative Thoughts |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Excessive Worry | <input type="checkbox"/> Concentration Problems |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Anxiousness | <input type="checkbox"/> Obsessions/Compulsions |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Relational Difficulties/Conflicts |
| <input type="checkbox"/> Eating Problems | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Tearfulness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Inappropriate anger |
| <input type="checkbox"/> Mania | <input type="checkbox"/> Delusions/Hallucinations | <input type="checkbox"/> Self Injurious Behavior |
| <input type="checkbox"/> Dissociative States | <input type="checkbox"/> Increased Alcohol Use | <input type="checkbox"/> Use of Illegal Substances |
| <input type="checkbox"/> Thoughts of Death/Suicide | <input type="checkbox"/> Other Symptoms _____ | |
- Other Symptoms _____

When would you estimate that these symptoms began? _____

What has been the course of your symptoms? (i.e. getting better, worse, or staying the same)

Have you experienced similar symptoms before? When? _____

What have you tried that has made the symptoms better/worse? _____

What (if any) medications are you taking or have you tried? _____

Have you consulted other health professionals concerning your symptoms? _____

Do you smoke? Y N Do you consume alcohol? Y N How many drinks per week? _____

Have you ever used an illegal substance or legal substance illegally? If so, please share when and for how long. (Substance use can create or influence depression/anxiety) _____

Do you have a supportive/spiritual community? Explain _____

Briefly describe your relationships in your family of origin: _____

Briefly describe your current significant relationships: _____

Have you ever been the victim of abuse or experienced a traumatic event? Explain _____

Have you ever been married before? Explain _____

Please share any other information you want me to know before we begin. _____

THERAPIST NOTES: _____

Diagnostic Impressions: _____

Initial Treatment Plan: _____

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WHAT IS INVOLVED IN THE COUNSELING PROCESS?

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration, loneliness, and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. It requires a very active effort on the part of both the client and therapist. In order to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy has shown to have benefits for people who undertake it. Therapy often leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. Each individual's progress varies.

Our first session will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work will include and an initial treatment plan to follow, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If at any time you feel that the issues discussed have not been resolved to your satisfaction, I will be happy to help you to secure an appropriate consultation with another mental health professional. If you decide to proceed with counseling, usually a **session lasts 45 minutes** in duration. Some sessions may be longer or shorter depending on your specific needs and treatment goals. **Once this appointment hour is scheduled, you will be expected to pay your therapists full session rate or a maximum of \$75 cancellation fee unless you provide 24-hour advance notice of cancellation with the exception of extreme emergencies (accidents, emergency illnesses, etc.)** Work conflicts would not be reasons for this fee being waived. Frequent cancellations and rescheduling may result in termination and referral by your counselor and will be discussed by phone or in person before this occurs. **If a minor child or client being covered by a guardian's insurance policy (thus making them the guarantor) incurs fees, the guardian/guarantor will be held legally responsible for any fees occurred including cancellation fees.**

WHAT FEES ARE INVOLVED IN THE COUNSELING PROCESS?

My standard fee is \$_____ for an initial session, \$_____ for a 45 minute session and \$_____ for a twenty- minute session. (The actual cost to you may vary due to insurance and copays or a sliding scale agreement. If the client is using an EAP, the client will not be charged as long as their sessions are covered by the EAP.) If a licensed therapist is filing out of network insurance on behalf of the client, clients are responsible for the agreed upon rate for all sessions at the time the session occurs and they are also responsible to notify the therapist when the deductible has been met and their fee would be reduced. If the client overpays, a credit or refund would be issued at their request. **If a client has a change in insurance, it is their responsibility to notify their therapist and provide a copy of their new insurance card.** If this change results in unpaid sessions, the client will be financially responsible at the therapist's usual and customary rate listed above or a rate negotiated between them and the client when the discovery occurs.

It is my practice to charge \$_____ on a prorated basis for other professional services you may require, such as report writing, telephone conversations which last longer than 5 minutes, preparation of records or treatment summaries, or the time required to perform any other service which you may request of me. **A minimum fee of \$50 is charge for copies of records or reports and minimum of two weeks notice is required.**

COURT RELATED FEES: I have no forensic experience and being a master's level counselor or intern would generally not be considered an expert witness. If you become involved in litigation that requires my participation including but not limited to divorce, custody disputes, or cases involved CPS or criminal activity, and due to the complexity and difficulty of legal involvement, I charge **\$150 per hour** for preparation for and attendance at any legal proceedings. Also, a **\$1500 retainer** will be required up front if a subpoena is issued or court appearances are requested.

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to at the time these services are requested. Payment can be made in the form of cash or a personal check. **Sessions will be discontinued if an outstanding balance**

develops without the establishment of payment arrangements and an interest rate of 18 % will be added to all outstanding balances including those created by returned checks. There is a \$50 returned check policy.

Committing check fraud is a felony and if a returned check is not cleared within a month, this matter may be turned over to the Collin County District Attorney's Office for Prosecution. If an unpaid balance does occur, this can be turned over to a credit recovery service which may report medical collections to the standard credit reporting agencies adversely affecting a client(s)' credit score.

IS WHAT WE DISCUSS CONFIDENTIAL?

In general, the confidentiality of all communications between a client and a therapist is protected, and I can only release information about our work to others with your written permission. However, there are a number of exceptions including some legal proceedings. If I believe that a client presents a **danger to him/herself or to someone else**, I am required to take protective actions. If I believe that a **child, an elderly person, or a disabled person in being abused**, I must file a report with the appropriate state agency. Should such a situation occur, I will make every effort to fully discuss it with your before taking any action.

Understand that confidentiality is not the same as statutory privilege. If I receive a legal subpoena or if you've given permission for exchange of information for insurance purposes, details regarding our sessions may be disclosed. I will try and make every effort to contact you first should this occur. Please refer to the disclaimers on our Release of Confidential Information form.

I may occasionally find it helpful to consult about a case with other professionals. In these consultations, I make every effort to avoid revealing the identity of my client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel that it is important to our work together. *All interns and students are involved in weekly supervision sessions where your identity will remain obscured but your case will be discussed in detail.*

ADDITIONAL EXCEPTIONS

******Please note that any individual attending group, joint marriage sessions and/or any family sessions has access completely to the records of that session.******

- **MARRIAGE COUNSELING:** If you are involved in marital counseling, confidentiality does not include your spouse and is left up to my discretion. This will be explained further in your initial session.
- **PARENTS OF ADOLESCENTS:** *If the client is a child or adolescent and is engaging in reckless behavior or persistent substance use, we will discuss the situation and I will give him/her the opportunity to inform their parent/guardian in my presence since this constitutes harm to self.* Please understand that we will not betray confidences of parental defiance or rebellion that are not life threatening. We will make every effort to encourage the minor to be forthright with their guardians as transparency is a recognized dynamic of a healthy relationship. If a parent feels betrayed by our keeping of confidentiality, we encourage the family to schedule a family session to discuss this matter.
- **PARENT CONSULTATIONS:** Also, in counseling involving a minor child as the identified patient, the rights of confidentiality extend to them only. If you share information during a parent consultation that would impact their treatment or if the child is present, realize that either parent has access to the child's records and anything said by the other parent would not be considered confidential during a family session or parent consultation since they are not a counseling patient.
- **LEGAL ISSUES:** If at any time you involve any staff member or ACA as a company in legal proceedings including but not limited to requesting files for an attorney, having a subpoena issued by an attorney or court, requesting a staff member give a deposition, or verbally or in writing threatening to name a staff member or the organization in a lawsuit, we will disclose general case information to our attorney in order to follow best legal and ethical practices when addressing these issues.

By initialing here, I am recognizing and agreeing to these exceptions to confidentiality which could pertain to records requests made at a later date.

Clients' Initials _____

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns you may have at our next meeting. The laws governing these issues are quite complex, and I am not an attorney. While I am happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable.

****Electronic Communication**:**

I acknowledge that if I communicate by text or email with my counselor that this information is often carried around in their cell phones and therefore am consenting to their response using the same format and have been cautioned regarding the limits of confidentiality existing with electronic communication. I acknowledge that I have been encouraged that counseling issues and therapeutic questions outside the counseling office are to be addressed by confidential voicemail or in session only. If I choose to use any electronic form of communication, I do so at my own risk and have waived my rights to having my identity and information protected when using this form of communication. I have also been informed that my therapist does not always have immediate access to electronic communication and that it is preferred that cancellations and scheduling should be handle by telephone.

By initialing here, I am recognizing and agreeing to the risks involved in utilizing electronic communication should I request the therapist utilize this form of communication when scheduling appointments or for any other situation that I initiate.

Clients' Initials _____

CAN I SEE MY RECORDS?

Both law and the standards of my profession require that I keep appropriate treatment records. You are entitled to receive a copy of the records. Because these are professional records, they can be misinterpreted and/or upsetting. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Most often a summary is supplied because handwriting and notes are for my use in treatment and difficult to understand clearly. Clients will be charged an appropriate fee for any preparation time required to comply with an information request including a minimum fee of \$50 and must give two weeks notice to allow for these records to be prepared. **If for any reason I would become unavailable due to illness, injury, or death, please contact Michelle Nietert, LPC-S, at 972-979-9720. If she is not available, please contact Shannon Brown, LPC-S at 972-880-1722.** She will become custodian of all files that have not been destroyed. Files are shredded six years after the date of our final session or in compliance with State Board and HIPAA guidelines.

HOW DO I CONTACT YOU?

I can be reached by leaving a message on my voice mail using the number I have published on the ACA website or the on call number: 214-509-6888. I will make every effort to return your call within 48 hours with the exception of weekends and holidays. **In emergencies, my services should not be used for crisis intervention. You can leave me a message after contacting 911, your physician, the emergency room of your choice, or a licensed mental health facility.** If I am unavailable for an extended time, I will notify you by my outgoing message. Please call our main number if you should need further assistance.

ART THERAPY

At times, art therapy may be used in your treatment, especially that of children and adolescents. I sometimes use examples of artwork done in therapy during professional trainings. All markings of identity are disguised and names are changed to protect the identity of the clients. **Please initial here giving permission for any artwork created during counseling to be used for professional training only.** _____

GIFTS

Please understand due to ethical standards set forth by the state of Texas and my professional associations, it is my policy not to receive gifts.

COUNSELING CONTRACT

I, the client(s) signed below, affirm the accuracy of the personal information provided herein, and have read the information above and agree to the conditions set forth therein. I hereby agree to the following conditions:

1. I am committed to changing my life by making positive choices.
2. I will keep the appointment time, or will call to cancel 24 hours in advance with a legitimate excuse.
3. I will fulfill the homework assignments.
4. I will begin to build a support network outside of the counseling office in order to sustain personal growth.
5. I understand that confidentiality cannot be guaranteed as indicated in the previous pages including limits regarding harm to self or others, supervision and consultation, marriage and family counseling, legal issues, and electronic communication.
6. I understand that early termination of counseling is required in writing and it is most beneficial to exit counseling with a closure session.
7. I understand that I am financially responsible for any fees/co-payments incurred. I am also responsible for any fees not covered due to my not following the procedures set up by my insurance provider if applicable or not providing the information in a timely manner for billing purposes. I understand that I am responsible for any fees not covered by insurance. I also understand that if I am the guarantor of a minor/client, I am responsible for any fees they may incur.
8. I understand that if I am seeing an intern/student that they are being supervised by Michelle Nietert, LPC Supervisor.
9. I also acknowledge receipt of **Notice of Policies and Practices to Protect the Privacy of Your Health Information and ACA Informed Consent.**
10. **I acknowledge that if I am the signing on behalf of a minor child, I am their legal guardian and have the power to give medical/psychological consent.** I have been informed a copy of my divorce decree proving this is required for any follow up visits. I also am aware of ACA's philosophy that making a counselor reveal records or appear in court is rarely therapeutic for children participating in therapy because it destroys their safe place.

(Signed)_____ (Date) _____

(Signed)_____ (Date) _____

(Guardian)_____ (Date) _____

(Counselor)_____ (Date) _____

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Notice of Policies and Practices to Protect the Privacy of Your Health Information
*THIS NOTICE DESCRIBES HOW COUNSELING AND MEDICAL INFORMATION ABOUT YOU MAY
BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.*

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”
 - *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
 - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against one of our counselors with the State Board of Licensed Professional Counselors, the Board has the authority to subpoena confidential mental health information from us relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under

state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If it is determined that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to your emergency contact or medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Counselor's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at this office. Upon your request, we will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your access to PHI may be denied under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Counselor's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post notice of such revision on our practice web site, <http://www.allencounselingassociates.com> . We may also elect to notify you by mail at the billing address which you have provided to us.

V. Complaints

If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may contact Michelle Nietert, M.A., LPC Supervisor at 972.979.9720. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003 .