North Texas Counselors
305 E. McDermott, Ste A
Allen, Tx 75002
972-984-2071
www.NTxCounselors.com

Jackie Burson, MS, NCC, LPC-S, RPT-S
Natalie Delgado, MA,NCC, LPC
Tracie Hensley, MS, LPC, RPT
Brooke Rodriguez, MS, LPC
Elisa Swartz, MS, LPC

ADULT INTAKE FORM

Today's Date:____/____/____ Referred By:_____
Name of Client
_____
Date of Birth _____ Age _____
Sex: M F Race____ __Religion_____
Patient Social Sec #:_____
Patient Drivers License #:_____
Insurance Subscriber Social Sec #:_____
Street Address _____ _____
City_____ Zip_____
Home Phone _____
Cell Phone _____
Email_____
Where can we leave messages for you:_____

Employer _____
Work Phone _____

Job Title _____
Education (Yrs Completed)_____

Marital Status (Circle): Single / Married / Separated / Divorced / Widowed / Cohabitating

Spouse Information (if applicable)

Name of Spouse _____
No. of years married _____
Date of Birth _____Age _____
Employer _____
Education (Yrs. Completed)_____
Job Title_____

Who currently lives in your home?

Full Name	Sex	Age	Comments
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

Why are you currently seeking counseling?
_____
_____
_____
_____
_____

List your current concerns in the order of their importance (that brought you to counseling)
_____
_____
_____
_____
_____
_____
_____
_____

Is there a history of any of the following? (Please check all that apply):

- o Suicide Attempts
- o ADD / ADHD
- o Major Depression
- o Grief Issues
- o Anxiety
- o Sexual Abuse
- o Domestic Violence Contact with Child Protective Services
- o Drug or Alcohol Abuse or similar agency
- o (Self or Family)

Other_____

What do you hope to gain from counseling at this time?
_____
_____
_____
_____
_____
_____
_____
_____

Have you had any previous counseling? _____
If so, where and when and with regard to what issues?

_____

Name of previous therapist

_____
Address

_____
Dates of therapy? From _____To _____
City _____ Zip _____
Issues of concern

_____
_____
_____
_____
_____
_____

How did you find us?
Internet _____
Referral (if so, who?)_____
Other _____

Reason for termination of therapy

_____
_____
_____
_____
_____
_____

Medical History
Physician's Name

_____
Address _____
City _____ Zip _____
Phone:_____

Current Medications

_____
_____

Current Medical Concerns

_____
_____

Is there a current mental health diagnosis by a primary care physician, psychiatrist, psychologist or other mental health professional?

_____
_____
_____
_____
_____

Therapy Policies and Services
Welcome! We are committed to providing you with quality care. This information packet is intended to acquaint you with what you can expect, and address some of the typical areas of concern, especially for the first-time client.

Qualifications: Jackie Burson, Director, is a graduate from Texas Woman's University in Counseling and Development. All therapists are licensed and qualified to counsel according to the Texas Department of Health. Our formal education has prepared us to do individual counseling with children, adolescents/teens, adults and families.

Experience: Throughout our master's program and under supervision since completing our formal education, we have counseled many individuals, family and group sessions in the school and agency setting, clinical internships, and in private practice.

Counseling Relationship: While we work together, our sessions may be very intimate psychologically, but ours is a professional relationship rather than a social one. Please do not invite us to social gatherings, offer us gifts, ask us to write references for you, or ask us to relate to you in any way other than the professional context of our counseling sessions. You will be best served if our sessions concentrate exclusively on your concerns. Our in-person contact will be limited to counseling sessions you arrange with us. You may leave messages for your counselor at 972-984-2071 and we will return your call as soon as possible. If you experience a mental health emergency, obtain crisis services by calling 911 and/or by going to a nearby hospital emergency room.

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Client Rights: Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though we do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of our counseling techniques or suggestions that you believe might be harmful.
We assure you that our services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with our services, please let us know. If we are not able to resolve your concerns, you may report your complaints to the Texas Department of Health, 512-834-6658.

Conditions of Ongoing Counseling: If you have been in counseling or psychotherapy during the past seven years, we may require you to sign a release so we may communicate with and/or receive copies of records from the professional(s) from whom you received mental health services. While you are in counseling with us you agree not to maintain or establish a professional relationship with another mental health professional unless you first discuss it with us and sign a release that enables us to communicate with the other mental health professional(s). If you decide to maintain or establish a professional relationship with another mental health professional against my advice, we may consider this your decision to change counselors and reserve the right to terminate your counseling.
We also reserve the right to postpone and /or terminate counseling of clients who come to session under the influence of alcohol or drugs. In addition, we reserve the right to terminate counseling of clients who do not comply with the medication recommendations of their psychiatrist or physician.

Referrals: We recognize that not all conditions presented by clients are appropriate for treatment at this facility. For this reason, you and/or we may believe that a referral is needed. In that case, we will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and /or alternatives. Certain aspects of treatment

may require evaluation through psychological testing or medication. In such cases, a referral to a psychiatrist or medical doctor may be made. Ongoing dialogue with these professionals would be maintained to manage the counseling process effectively.

Records and Confidentiality: All of our communication becomes part of the clinical record. Adult client records are disposed of five years after the file is closed. Minor client records are disposed of five years after the client's 18th birthday. Most of our communication is confidential, but the following limitations and exceptions do exist: a) We determine that you are a danger to yourself or someone else; b) you disclosed abuse, neglect, or exploitation of a child, elderly, or disabled person; c) you disclose sexual contact with another mental health professional; d) We are ordered by a court to disclose information; e) you direct me to release your records; or f) We are otherwise required by law to disclose information. If we see you in public, we will protect your confidentiality by acknowledging you only if you approach us first.

Fees:. In return for a fee of *$ 100* per 50 minute session with an LPC or $60 per 50 minute session with an LPC-Intern, we will provide counseling sessions for you. By consenting to treatment, you acknowledge (to you or your minor child) and agree to pay at each session. Cash, credit cards or personal checks made out to "*North Texas Counselors*" are acceptable for payment and due by the end of each session. Some insurance companies may cover part of this cost. You may pay your insurance co-pay at the time of session. If records are requested at any time by yourself, lawyers or the court, there is a $30 fee. If a credit card is declined for any reason, there is a $5 fee added to the next payment.

PLEASE INITIAL BELOW:

_____**PATIENT BALANCE POLICY**: After filing with the insurance company on file, we will credit your account the remaining balance after your co-pay or deductible. Any quote received from insurance will be considered an estimate only and any payment will be considered a partial payment only until such time that the insurance company processes your claim.

_____**PATIENT SESSION FEES**: I am aware that all current balances, co-payments, co-insurance and deductibles are due and payable at your session time for services being rendered. We will not accept payment for your session at a later time. We accept cash, check, VISA, Mastercard or Discover. Please be aware that we do not accept post-dated checks. If you are the parent/guardian for a minor, you can leave a credit card on file to make sure each session is paid for.

_____ **PATIENT INSURANCE POLICY:** I am aware that, I, the patient, am responsible for knowing my insurance benefits (including deductibles, co-pays, pre-authorization requirements and/or any exclusions to the plan). There are times insurance companies quote benefits over the phone and we don't find out until several months later the benefits were incorrect. If this happens, North Texas Counselors might be asked to pay money back to your insurance called a refund request. If we are issued a refund request, it is the patients responsibility to pay us the amount we are asked to pay back to your insurance carrier.

_____ **COLLECTION AGENCY:** I am aware that North Texas Counselors utilizes a collection agency for unpaid bills. If your account is transferred to collections, any and all fees assessed by the agency will be added to the balance on your account, to include, but not limited to, an additional percentage of your balance and attorney fees. Any patient sent to collections forfeits any future appointments unless the balance is paid in full but may be permanently dismissed from the practice.

_____**DIAGNOSIS:** I give consent to North Texas Counselors to perform necessary procedures to diagnose, treat and care for the mental health needs of my child or myself and understand a diagnosis will become a permanent part of the medical record.

_____**LEGAL FEES:** I understand that if North Texas Counselors becomes involved in litigation that requires our participation (even if the subpoena is sent from the opposite side of the case), and due the complexity and difficulties of legal involvement, **we charge *$250* per hour for preparation for and/or attendance at any legal proceedings. (A $500 fee is due upfront before going to court).**

_____**RETURNED CHECK FEE:** I understand there is a $25 fee for checks returned for any reason. We will require a credit card on file for future payments if a check is returned. If payment is not made in a timely matter, we may seek all additional legal remedies provided to us under Texas Law.

_____**NO SHOW/CANCELLATION COURTESY:** We are committed to making you an appointment at your earliest convenience; likewise, we require a call at least 24 hours in advance if you are unable to keep your appointment. If you "no show" for an appointment or cancel with less than 24 hours notice, you will be charged a $60 fee. No exceptions. Missed appointments cannot be filed with insurance.

I understand and agree to the above initialed items

Client's Name:_____

X_____ X_____
Signature Date

X_____ X_____
Counselor's Signature Date

	During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight Rare** less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
I. Depression	1. Little interest or pleasure in doing things?	0	1	2	3	4
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4
II. Anger	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4
III. Mania	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4
IV. Anxiety	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4
	7. Feeling panic or being frightened?	0	1	2	3	4
	8. Avoiding situations that make you anxious?	0	1	2	3	4
V. Somatic	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4
VI. Suicidal	11. Thoughts of actually hurting yourself?	0	1	2	3	4
VII. Psychosis	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
VIII. Sleep	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4
IX. Memory	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4
X. Repetitive	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4
XI. Dissociation	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4
XII. Personality	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4
XIII. Substance	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4

North Texas Counselors
HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
Effective August 1, 2004

Use and disclosure of protected health information for the purposes of providing professional counseling services is sometimes required. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

-*"PHI"* refers to information in your health record that could identify you.
-"*Treatment"* is when we provide, coordinate, or manage your healthcare. An example would be when we consult with another healthcare provider (PCP, psychiatrist).
-*"Payment"* is when we obtain reimbursement for your healthcare. Examples of payment: (Disclosing PHI to your insurance carrier to determine eligibility or coverage).
"*Use*" applies only to activities within our office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

Treatment
Use and disclose health information to:
1.Provide, manage or coordinate care to consultants, referral sources, or physicians.
2. As patients gives permission via "Informed Consent" form.

Healthcare Operations (activities that relate to the performance and operations of our practice).
-*"Disclosure"* applies to activities outside of our office such as releasing, transferring, or providing access to information about you to other parties.

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 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.

Use and disclose health information to:

1. Review of treatment procedures.
2. Review of business activities.
3. Staff training and care within our practice.
4. Compliance and licensing activities.

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

1. 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 Dept of Protective and Regulatory Services, The Texas Youth commission or to any local or state law enforcement agency.
3. Adult or 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 Dept of Protective and Regulatory Services.
4. 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 medical health information from us relevant to that complaint.
5. Judicial or Administrative Hearings: 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 legal 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.
6. Serious threat to health or safety: If it is determined that there is a probability of 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 to medical or law enforcement personnel.
7. Workers Compensation: If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employers insurance carrier.

By signing below, you attest that you have read and have been made aware of my rights of confidentiality as a mental health consumer. Full HIPPA Compliance Rules and Regulations are posted in the therapist's office at all time, and may be read and copied for consumer upon request.

_____ _____

Client/ Guardian Printed Name Relationship to Client

X_____ _____

Client/ Guardian Signature Date Signed

NORTH TEXAS COUNSELORS
305 E. MCDERMOTT, SUITE A
Allen, Tx 75002

CREDIT CARD INFORMATION

Credit card information will be kept on file and used as payment for your therapy sessions. Other forms of payment include cash and check. Your credit card will show a payment to "North Texas Counselors".

Name on Card:

_____

Card Number:

_____

3-digit verification code (on back of card): _____ Exp: _____

Circle one: Visa Mastercard Discover

"By signing below, I authorize my credit card to remain on file and used for the purposes of counseling services with North Texas Counselors for the below patient. Should I fail to give 24-hour cancellation notice, or my insurance claim is rejected, this card may be used without notice as payment for the late cancelled session or patient balance."

Cardholder Printed Name:

_____

Cardholder Signed Name:

_____

Client Printed Name:

_____