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

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NORTH TEXAS COUNSELORS

New Client Information- Families & Couples

Client Name:(his) _____

Address:_____Phone:_____

City:_____State:_____ Zip:_____

Email _____

Age:_____Date of Birth: _____

Client Name:(her) _____

Address:_____Phone:_____

City:_____State:_____ Zip:_____

Email _____

Age:_____Date of Birth: _____

Employer(his):_____

Employer(her):_____

Why are you and your spouse or family seeking counseling:

_____

_____

_____

How did you hear about us?_____

How would you rate the intensity of the problem or concern that brought you in:

1 2 3 4 5

Not Intense Moderately Intense Extremely Intense

How long have you had the current problem:

_____

In what ways have you attempted to cope with this problem:

_____

_____

Have either one of you been in counseling before?

_____

If so, please provide a brief description of treatment:

_____

_____

_____

Former Counselor:_____ Phone:_____ Dates:_____

ABOUT HER

Where did you attend public school?_____

Where did you attend college?_____

Relationships

Relative	Name	Living (Yes/N0)	Age or age at death	Deceased? Yes No	Occupation

Describe any other significant relationships other than relatives:_____

Please check any past or present problems/concerns in your family:

___Divorce ____Serious Illness ____Alcohol/Drug Abuse

___Relocations ____Psychiatric Disorders ____Physical/Sexual Abuse

___Legal Problems ____Eating Disorders ____Attempted Suicide ___Financial Crisis ____Parenting/Step Parenting ____Health

___Arguing ____Codependence ____Debt

___Stress ____Failure/Fears ____Gambling

___Grieving ____Sexual Conflicts ____Sadness

___Relationship Problems ____Self-Esteem ____Phobias

___Perfectionism ____Panic/Anxiety Attacks ____Mood Swings

___Anger/Agression ____Career Concerns ____Laziness

Other_____

Did you experience any of the following problems, if yes please explain:

Family abuse, legal problems, learning problems in school, difficulty growing up?

Please explain:

_____

_____

_____

Who in your family do you currently feel closest to?_____

Most distant from?_____In most conflict with_____

Who is your doctor:_____ Number:_____

When was your last visit:_____

List all medications/drugs you are currently taking or have taken within the last year:_____

_____

Are there any health concerns from your doctor?

_____

_____

ABOUT HIM

Where did you attend public school?_____

Where did you attend college?_____

Relationships

Relative	Name	Living (Yes/N0)	Age or age at death	Deceased? Yes No	Occupation

Describe any other significant relationships other than relatives:_____

Please check any past or present problems/concerns:

___Divorce ____Serious Illness ____Alcohol/Drug Abuse

___Relocations ____Psychiatric Disorders ____Physical/Sexual Abuse

___Legal Problems ____Eating Disorders ____Attempted Suicide ___Financial Crisis ____Parenting/Step Parenting ____Health

___Arguing ____Codependence ____Debt

___Stress ____Failure/Fears ____Gambling

___Grieving ____Sexual Conflicts ____Sadness

___Relationship Problems ____Self-Esteem ____Phobias

___Perfectionism ____Panic/Anxiety Attacks ____Mood Swings

___Anger/Agression ____Career Concerns ____Laziness

Other_____

Did you experience any of the following problems, if yes please explain:

Family abuse, legal problems, learning problems in school, difficulty growing up?

Please explain:

_____

_____

_____

Who in your family do you currently feel closest to?_____

Most distant from?_____In most conflict with_____

Who is your doctor:_____ Number:_____

When was your last visit:_____

List all medications/drugs you are currently taking or have taken within the last year:_____

_____

Are there any health concerns from your doctor?

_____

_____

About Your Family

Child's Name & age: _____

Child's Name & age: _____

Child's Name & age: _____

Child's Name & age: _____

Describe any past/current problems with children:

_____

_____

_____

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 seven years after the file is closed. Minor client records are disposed of seven 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. There is a $25 returned check fee.

PLEASE INITIAL THE FOLLOWING:

_____I authorize North Texas Counselors (Burson Counseling, PLLC) to submit claims to my insurance company and release any information (including notes/treatment plan) relating to insurance claims. I authorize payment of my insurance benefits directly to North Texas Counselors.

_____I am responsible for all charges and will pay the full amount, even if for any reason a claim is denied by my insurance. **(Patient is responsible for knowing their benefits, session limits and if pre-certification is required).**

_____I give consent to North Texas Counselors (Burson Counseling, PLLC) 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.

_____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).**

_____There is a $25 returned check fee. (If a check is declined, we have the right to request payment by cash or credit card). There is a $5 fee for declined credit cards. There is a $30 fee for requested records.

_____**Cancellation: If you need to cancel an appointment, 24 hours notice is required. If you miss an appointment without sufficient notification you WILL BE CHARGED $60. Missed appointments CANNOT be filed with insurance.**

_____ANY CREDIT FROM INSURANCE CLAIMS RECEIVED MAY ONLY BE USED FOR CREDIT TOWARDS FUTRE COUNSELING SESSSIONS. CREDIT WILL NOT BE DIRECTLY GIVEN BACK TO CLIENT.

Client'sName:_____

X_____

Signature Date

X_____

Counselor's Signature Date

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