CONFIDENTIAL CLIENT INTAKE INFORMATION
109 Enterprise Parkway Suite 201, Boerne TX 78006, 830.331.4032
***Thank You* for Printing Clearly**
September 9, 2016

Today's Date _____ 1st session scheduled _____

Client's Last Name _____First _____MI____ SSN_____

Mailing Address _____
(Street) (City) (Zip)

Email (for appointments/administration, not counseling) _____

Home #: ( ) _____-_____ Cell #: ( ) _____-_____ Work #: ( ) _____-_____
You prefer to be called/leave messages Home ( ) Cell ( ) **Preferred reminder (circle one) voice or text**

Birth Date _____ Gender ____ Referral Source: _____

If client is a student, school attending: _____

Responsible Party (insurance/payment/for client, must be present to sign)

Subscriber/Name (printed): _____ Phone: _____

DOB: _____ Relationship to Client: _____

Mailing Address_____
(Street) (City) (Zip)
Employer: _____ Insurance ID #: _____ Group: _____

Insurance Company Name: _____ Phone #: _____

ALL FEES ARE DUE AT THE TIME OF THE APPOINTMENT. Fees are due for any scheduled appointment **unless the appointment is cancelled at least 24 hours in advance**. If the provider is not a network provider for my insurance company, I understand that it is necessary to first pay the fees and then file with the insurance company for reimbursement. Initialing and signing below shows **I agree that all overpayments can be applied to future sessions**.
_____ I authorize the release of any medical information requested by my insurance company that is necessary to process this claim or for audit purposes.
_____ I authorize payment be made to this provider for services rendered.

By signing this form, I am requesting treatment and give permission for the exchange of information between my insurance company, Susan Loveland (and associates), and credit/debit companies. I accept <u>avoidably</u> missed sessions will be billed on my credit/debit card unless I state or request otherwise in writing. I certify I have read and understand the HIPAA materials provided.

Debit/Credit Card
Type of Card: _____ Name on Card: _____ Payer Zip Code: _____

Card # (last 4 only) __ __ __ __ Exp Date: _____

Signed: _____ Date: _____

CONFIDENTIAL COUNSELOR-CLIENT INFORMED CONSENT
ACORN COUNSELING PLLC
109 Enterprise Parkway Suite 201 Boerne TX 78006, 830.331.4032

Purpose: Acknowledge consent to use and disclosure of health information, and clarify the professional counseling relationship and expectations.

Background: Master of Arts degree in counseling from St Mary's University (2006), Registered Play Therapist has experience and special training in play and art therapy and National Board for Certified Counselors (NCC) certification. Registered Play Therapist and Certified Eye Movement Desensitization and Reprocessing (EMDR) Therapist.

Limitations: LPC practice limited to individuals, couples, families, and groups of only clients who I believe have the capacity to resolve their own problems with my assistance. I believe people find happiness and contentment in their lives as they choose to gain awareness and self-acceptance. Clients understand that counseling is based on attending regularly scheduled counseling appointments and talking openly with their counselor. Clients realize they may encounter troubling emotions in the course of counseling. Although counseling is usually a beneficial process, clients understand that there can be no guarantees concerning the outcome of treatment or the achievement of specific goals. However, they can expect to be heard and accepted as a human being of value and worth. Signing below constitutes consent to the counselor to provide appropriate treatment (to me or to the minor for whom I am parent/guardian) in an ethical and professional manner.

Professional Relationship Rather Than a Personal One. Contact will be limited to the paid sessions or phone calls to schedule sessions. Please do not invite me to social gatherings, offer gifts, or ask me to relate to you in any other way than in the professional context of our counseling sessions. You will be best served if our relationship remains strictly professional and our sessions concentrate exclusively on your concerns**. All information that is shared in therapy is held in confidence with legal exceptions listed below and will not knowingly be shared with another medical person without your written consent. There is a vulnerable aspect in all faxes, electronic communication devices that MAY NOT BE PREVENTABLE, regardless of safeguards and reasonable measures.**

Goals: Self-awareness, self-acceptance, those mutually accepted by our professional relationship. Please discuss with me first if you have any concerns about aspects of our relationship and you may contact the State Board in the event that you do not find resolution.

Reason for Counseling: _____

Are there suicide concerns? Yes ( ) No ( ) Homicidal concerns? Yes ( ) No ( ) Drug Usage? Yes ( ) No ( )

Goals for Counseling:

_____
_____
_____

On a scale of 1 to 5, 1 being least and 5 being most, how willing are you/the client to make changes to improve the situation (circle a #)? 1 2 3 4 5

Termination: You or I may choose to discontinue the counseling relationship at any point. I will be supportive of that decision and appreciate you discussing this with me. If counseling is successful, you should be able to face life's challenges in the future without my support. I expect open communication if there is ever a problem with the counseling service provided. Last session or no response after 60 days of last session or communication constitutes termination. We must terminate or refer to other therapists if counseling is no longer a benefit to you, the client, or I feel that I can no longer be helpful.

Please initial by each statement acknowledging acceptance and understanding of expectations:

1. Records and Confidentiality

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your/client's privacy. Implementation of HIPAA began officially on April 14, 2003. This form is an agreement between you/the client, and this clinic. When we use the word "you" it refers to you, your child, relative, or you as a client. When we examine, diagnose,

treat or refer you, we will be collecting what the laws call Protected Health Information (PHI) about you. We need to use this information here to decide what treatment is best for you and to provide treatment to you. We may also share your information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

All of our communication becomes part of the clinical record, which is accessible to you upon request. The complete privacy notice is attached to the clipboard behind this contract and/or available at the reception desk or in the waiting room. Occasionally the therapist may find it helpful to consult with other health professionals about your case or for scheduling, billing, and quality assurance who have been trained and agree to protect your personal health information (PHI). The counseling practice is advanced through publication and presentations. Data obtained through our professional relationship may be subject to use in these venues. It is understood and agreed that any data released will be disguised. Note: Reasonable and minimum standards are applied to protecting electronic and telephonic communication of your privacy information. No communication is 100% protected; signing below acknowledges accepting risk related to supporting the client's care. **I am a mandatory reporter**, and will keep confidential anything you say to me, with the following exceptions:

a. According to state and local laws, therapists must report to the appropriate agencies all cases of physical or sexual abuse or neglect of minors or the elderly.

b. According to state and local laws, therapists must report to the appropriate agencies all cases in which there exists a danger to self or others.

c. When authorized by the recipient of services, in order to process medical insurance claims and authorized payment of benefits.

d. In the event that a patient is in need of emergency services and other medical personnel need to be contacted.

e. If you become involved in specific kinds of legal proceedings, the courts may subpoena information concerning your treatment.

f. Susan Loveland prefers using email only to arrange or modify appointments. However, if you choose to communicate by email, be aware that all emails are retained in the logs of your and Susan Loveland's Internet service providers. Confidentiality can therefore not be guaranteed

I n the event of the therapist' death, your records are stored and accessible by Acorn Counseling PLLC, or Thomas Preininger at 830.331.4032. If, due to changing laws, we are required to change our Notice, you may get a copy from us by requesting one. You have the right to ask us not to use or share your information by requesting this in writing; we are not required to agree to these limits, but will do what we can to honor your wishes. You also have the right to revoke your agreement, also in writing. Records requests must be in writing.

2. **IF CLIENT IS A MINOR**: I give permission for this minor child to receive counseling without a parent or guardian present, and **agree to provide a full copy of the custody documents prior to first session and whenever those documents change (example: temporary to permanent custody)**. Children under the age of 18 years will be treated only with legal guardian or parental consent. Signing this form constitutes acknowledgement that you are the guardian (as established by the state or the divorce decree) of any minor present for treatment, children have gone to the restroom, wear appropriate play clothes, have eaten, and are ready for a 60-minute session with minimal interruptions. Reasonable precautions are taken for the care of clients. However, in the rare event that a child becomes sick or injures themselves, parents/guardians are expected to take responsibility for care/treatment.

Are both parents agreeing to counseling? If not, what is the problem and how will it be resolved?

_____

_____ [Initials]

3. Parents/guardians/family members are expected to remain quietly in the waiting room if not included in the session(s). Please do not bring children you may have to leave unattended. There are no babysitting resources and limited waiting room facilities. Initializing acknowledges Acorn and Associates will not be held responsible for supervising dependents/friends/relatives waiting for clients. [Initials]

Emergency Data

In case of emergency please list the name, address, and telephone number of two people in the San Antonio area that could be called.

Name _____ Name _____

Address _____ Address _____

City/State/Zip_____ City/State/Zip _____

Tel. Number_____ Tel. Number_____

Primary Care Physician (name/office practice name/phone number)

_____

_____

4. Spirituality: This practice offers Christian Counseling to include discussions about your God, optional prayer and scripture. Please indicate your desire for this kind of counseling Yes [Initials] No [Initials]
Do you believe religious/spiritual issues might play a role in your concerns/solutions? Yes [Initials] No [Initials]
Please describe your spiritual background:

5. Conflict: The therapist will play no active role in divorce/custody proceedings between _____ & _____, or share specific information that either party who confides during individual therapy sessions. The therapist's role will be to facilitate communication between members for reconciliation, and not serve as a witness for either party. Initials and signature below indicate understanding and agreement by these conditions. It is unethical for me to do any forensic evaluation during the course of treatment. **A complete printed copy of the custody agreement for children of divorce or have custody arrangements is required BEFORE sessions begin.**

[Initials]

6. Fees and Insurance Reimbursement

Initial fee of $120, subsequent individual sessions $120, couple/family session $120 when billing insurance are due at the beginning of each session. Cash or personal **checks to Acorn Counseling PLLC, debit or credit cards** are acceptable for payment. There is a discount for cash payment in full, and **a $30 fee for returned checks.** Please note that fees are subject to change and negotiated before payments are due. Clients or Guardians are responsible for full payment of fees, regardless of insurance company policies. **Clients are responsible for notifying this office when their insurance changes, and following through with their insurance account adjustments**. Consistency is an important part of the counseling process, and the appointment time that you schedule is reserved for you; it is not available to anyone else. Once an appointment has been scheduled, you will be expected to pay for it unless you provide notice of cancellation at least 24 hours in advance or were unable to attend due to circumstances beyond your control. Messages received on my answering system are acceptable for prior notice. Sometimes it may be necessary for me to reschedule an appointment and I will make every effort to contact you in advance to do so. **A fee of $60 will be assessed for avoidable, missed, no show, or short notice canceled sessions.** Professional services such as **consulting,** talking with attorneys or other providers, creating **treatment summaries, or records preparation are $60 payable prior to services delivered**. I require a **$500 retainer prior to action for legal documents or court appearances. I will not accept any gifts. Copies are $1 per page.**

[Initials]

7. Cell phones and other recording devices are expected to be **turned off** or set to vibrate only during sessions to minimize distractions. Signatures of approval by all parties involved are required prior to any recordings.

[Initials]

8. Physical contact may occur in the course of play or therapy in the form of supporting a child to protect from harm or protect boundaries. Reasonable and necessary precautions will be taken to provide positive growth, protect clients and therapists, and all situations cannot be anticipated**. It is the client/guardian's responsibility to address any concerns about this subject as soon as possible or prior to the next session.**

[Initials]

By signing below, I consent to treatment with the counselor signing below, acknowledge that I have read and understand this statement and the HIPAA Notice of Privacy Practices, and my questions have been answered to my satisfaction. I understand that my counselor and I will arrive at a mutually-agreeable treatment plan and an estimate of the probable duration of my counseling. Signing this document represents an agreement between therapist and client and may be revoked in writing at any time.

_____/_____
Counselor's Signature/Date

_____/_____
Client's Signature/Date

_____/_____
Client's Printed Name/Date

_____/_____
Parent/Guardian Printed Name/Signature/Date

CLIENT SELF-EVALUATION

Overall physical health: Excellent ( ) Good ( ) Fair ( ) Poor ( ) Declining ( )

On a scale from 1 – 10, 1 being least and 10 being most/worst ever, please circle your/client's current level of:

Physical pain?	1	2	3	4	5	6	7	8	9	10
Emotional pain?	1	2	3	4	5	6	7	8	9	10
Mental pain?	1	2	3	4	5	6	7	8	9	10
Spiritual pain?	1	2	3	4	5	6	7	8	9	10
Environmental pain?	1	2	3	4	5	6	7	8	9	10

Comments: _____
_____
_____
_____
_____

Define wellness or what life would be like when your concerns are resolved - what does it look like?
_____
_____
_____

Date (MM/YY) of last physical checkup: _____Recent weight changes: _____

Medical problems (please list all important present or past illnesses, injuries, surgeries, use the back if necessary):
_____
_____

Current Medications (prescriptions and over-the-counter)
_____
_____

Prescribing Physician(s) (name/phone): _____

Have you recently suffered a loss or major change (social, family, pet, business, move, etc.)? _____
If yes, please explain _____
_____

What is the worst thing that happened to you/the client? _____
_____
_____

What helped you/the client feel better? _____
_____

What is the best thing that happened to you/the client? _____
_____
_____

Have you ever been a victim of a crime? Yes ( ) No ( )
Are you coming to counseling for issues related to the crime? Yes ( ) No ( )
If yes, have you filed with Texas Crime Victims Compensation? Yes ( ) No ( )

If client is under age 18, who is the primary care giver (name, phone):
_____

Who is living in the house(s) of the client? Please list all if client lives in multiple dwellings (ex. joint custody)

Relationship	Name	Birth Date MM/DD/YY	Age	Gender	Occupation/ Grade

What are the client's strengths?
_____
_____
_____

What else should the therapist know?
_____
_____
_____
_____
_____
_____

Please rate each of the following concerns as they apply to you at the present time or within the last 6 months on a scale of 1 to 5 (1 = not a problem, no concern; 5 = a very strong or severe concern or problem)

_____ Alcohol/drug problems
_____Anger/temper
_____Anxious/Nervous/Fearful
_____Being close to people
_____Bereaved/Grieving
_____Danger
_____Eating
_____Guilt
_____Happy
_____Hopeful
_____Lonely
_____My identity/self esteem
_____Numb
_____ Relational/family problems
_____Sadness, crying, being 'down"
_____Seeing or hearing things that others don't
_____Sleep
_____Spiritual/religious
_____Things too painful to talk about
_____Talkative/confused
_____Loss appetite/upset stomach
_____Weight
_____Controlling thoughts
_____Concentrating
_____Trust
_____Pain
_____Drawing away from people
_____Energy

Willingness to own the problem & do something? Poor Good Very Good