CONFIDENTIAL CLIENT APPLICATION FOR SERVICES
109 Enterprise Parkway Suite 201, Boerne TX 78006, 830.981.5330
***Thank You* for Printing Clearly**
October 13, 2020

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 ____ How were you referred here? _____

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 more than 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 and all overpayments can be applied to future sessions**.
_____ (Initials) I authorize the release of any medical information requested by my insurance company that is necessary to process this claim or for audit purposes.
_____ (Initials) I authorize payment be made to this provider for services rendered.

By signing this form, I am requesting treatment, give permission for exchanging information between my insurance company if applicable, Susan Loveland (and associates), and credit/debit companies. I agree to keep a valid credit card on file and pay charges. I accept <u>avoidably</u> missed sessions will be billed on my credit/debit card. I certify I have read and understand the HIPAA materials provided.

Signed: _____ **Date:** _____

Debit/Credit/FSA/HSA Card Approval

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, 830.981.5330

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

Background: Master of Arts degree (**Not a Doctor**) 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. Provider is a Certified Eye Movement Desensitization and Reprocessing (EMDR) Therapy Therapist.

Limitations: LPC practice is 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, forgive and manage their boundaries. 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 and that all questions have been answered in an acceptable manner.

Professional Relationship Rather Than a Personal One. **Contact will be limited to 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. Therefore, technical equipment (phones) that may be deemed to cause interruptions are expected to be left out of session.**

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 office. When we use the word "you" it refers to you, your child, relative, or you as a client. When we examine, 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.

2. Communication. All of our communication becomes part of the clinical record, which is accessible to you upon written request. The complete privacy notice is posted in the waiting room and/or available online or at the reception desk. 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**.** Telephones are preferred to arrange or modify appointments and email for payment receipts only. However, if you choose to communicate by email, be aware that you accept all risk and liability and all emails are retained in the logs of your and Susan Loveland's Internet service providers. Confidentiality can therefore not be guaranteed. **Cell phones and other recording devices** are expected to be **left outside of session** or at least **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, **lack of signatures invalidates recordings**. [Initials]

3. Confidentiality only exists in civil cases, not in criminal cases. **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 (Under 18) or the elderly or disabled.

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, and the licensing board may request a copy, signing below acknowledges this understanding.** [Initials]

4. In the event of the therapist' death or incapacity, your records are stored and accessible by Acorn Counseling PLLC, or Thomas Preininger, LCSW, M. Div. at 830.981.5330. If, due to changing laws, we are required to change our Notice, you may get a copy from us by requesting one or obtain it online. 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. [Initials]

5. 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 with the minor and whenever those documents change (example: temporary to permanent custody)**. Children under the age of 18 years will be treated only with **all** legal guardians 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 and agree to psychological treatment for their child. Two signatures

are required unless one parent has full custodial care. I am responsible for children having 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. Parents/Guardians are responsible for notifying the therapist whenever there are concerns about particular toys that are not allowed to the child.
Are both parents agreeing to counseling? If not, what is the problem and how will it be resolved?

_____
_____[Initials]

6. 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]

7. 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]

8. Who May We Contact in Case of Emergency?

.
Name _____ Name _____
Address _____ Address _____
City/State/Zip_____ City/State/Zip _____
Tel. Number_____ Tel. Number_____
Primary Care Physician (name/office practice name/phone number)

_____

9. 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 religious/spiritual issues might play a role in your concerns/solutions? Yes [Initials] No [Initials]
Please describe your spiritual background:

10. 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 co-parenting plan for children of divorce is required BEFORE sessions begin. <u>No records for couples sessions will be released unless both consent to it.</u>** [Initials]

11. Fees and Insurance Reimbursement.

- **a.** Unless paying Private Pay, your insurance is a contract between you, your employer/source, and insurance company. Policies vary widely in services. **Initial fee of $120, subsequent individual sessions $120, couple/family session $120 when billing insurance or $100 private pay rate** are due at the beginning of each session. Cash or personal **checks to Acorn Counseling PLLC, debit or credit cards** are acceptable for payment.
- **b.** There is **a $30 fee for returned checks.**
- **c.** Please note that fees are subject to change and negotiated before sessions and payments are due.

d. Clients or Guardians are responsible for full payment of fees, regardless of insurance company policies.

e. Clients are responsible for notifying this office when their insurance changes, and following through with their insurance account adjustments.

f. 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 the answering system are acceptable for prior notice. Sometimes it may be necessary to reschedule an appointment and every effort to contact you in advance will be done so. **A fee of $60 will be assessed for avoidable, missed, no show, or short notice canceled sessions.**

g. Professional services such as **consulting,** talking with attorneys or other providers, or creating **treatment summaries are $60 payable prior to services delivered**.

h. A **$2,500 retainer + $300/hour is required prior to action for court appearances.**

i. Copies of records are $25 for the first 20 pages, $.50 per page thereafter, plus the actual cost of shipping if mailed. The provider is not required to provide the record until the fee is paid unless there is a medical emergency.

j. You should receive a receipt for every payment. The signature below constitutes agreement to request a receipt if one is not received or one is desired.

k. Initials indicate acceptance of financial policies and that if sessions go longer than the scheduled time of 60 minutes, the client or guardian accepts the additional fee of $50/half hour, unless the request is for public assistance for which there is no charge.

[Initials]

12. Recording sessions knowingly or unknowingly violates public rights and policies and will not be tolerated. Technical devices are required to be left outside of session. Outside video surveillance is for our safety and signing below acknowledges acceptance of the policy as well as knowing that any concern about it must be brought up promptly to the provider. [Initials]

13. I will not accept any gifts. [Initials]

14. Are you currently receiving counseling from another counselor? Yes ( ) No ( ) If you are currently receiving counseling services from a counselor, psychologist, psychiatrist, or religious leader, I may not be able to offer you services. Please discuss this with your therapist prior to sessions beginning or at any time this changes. [Initials]

15. Concerns or Complaints. If you have a concern or complaint with the service, we encourage you to first discuss the matter with your counselor. If you feel you cannot resolve it satisfactorily, you are encouraged to submit your complaint in writing to Acorn Counseling PLLC. An individual who wishes to file a complaint against a Licensed Professional Counselor may contact: Texas Behavioral Health Executive Council, 333 Guadalupe St., Ste. 3-900, Austin, Texas 78701, Tel. (512) 305-7700, 1-800-821-3205 24-hour, toll-free complaint system [Initials]

16. Additional policies. We work with people from all walks and orientations. We acknowledge and respect all personal and cultural beliefs that reflect different orientations toward life.

The patient has the right to terminate treatment at any time, and that the practitioner may terminate for one or more specified reasons, including, but not limited to, when the patient is unable to pay the fees for the services to be rendered. Such a disclosure may include the fact that one or more referrals will be made and that the termination, depending upon the circumstances, may consist of more than one session. In the event that the termination process requires more than one session, practitioners of course have the option to provide such session(s) on a pro bono basis.

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. Email receipts will be provided and statements are available upon request.

_____/_____ _____/_____

Counselor's Signature/Date Client's Signature/Date

_____/_____

Client's Printed Name/Date

_____/_____

Parent/Guardian Printed Name/Signature/Date
Legal Authority (attach supporting documentation)

CLIENT SELF-EVALUATION

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

On a scale from 1 – 5, 1 being least and 5 being most/worst ever, please circle you/client's current level of:

Physical pain? 1 2 3 4 5

Emotional pain? 1 2 3 4 5

Mental pain? 1 2 3 4 5

Spiritual pain? 1 2 3 4 5

Environmental pain? 1 2 3 4 5

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

INFORMED CONSENT FOR PANDEMIC TRANSITION (Oct 13, 2020)

Psychotherapists are not compelled to open their practices for face to face services unless they believe that they and their patients will be safe. Reasonable precautions are in place to protect both the patient and the public. This document contains important information about our decision (yours and mine) to resume or continue in-person services in light of the public health crisis. Please read this carefully and let me know if you have any questions as soon as possible. It will be an agreement between us when you sign the back of this page.

Decision to Meet Face to Face

We agree to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, we may require that we meet via telehealth. I understand that technology will be used and will not be the same as direct patient/healthcare due to the fact that I will not be in the same room as my provider. If I have concerns about telehealth, I will talk about it first and try to address the issue with my provider. I understand that, if we believe it is necessary, I may use to telehealth for everyone's well-being or be referred to another provider. If we decide at any time that we would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is deemed clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person and/or Telehealth Service

I understand that by coming to the office, I am assuming the risk of exposure to the coronavirus (or other public health risk). I understand there are risks to using technology, including interruptions, unauthorized access, and technical difficulties that may lead to an inability to obtain information sufficient for a confidential session, and that all reasonable precautions will be taken to minimize those risks. I understand that my provider or I can discontinue the telehealth visit if it is felt that the videoconferencing connections or environment are not adequate.

Your Responsibility to Minimize Your Exposure

To obtain services in person, I agree to take certain precautions which will help keep everyone (you, me, and our families, and other patients) safer from exposure, sickness and possible death. My failure or refusal to adhere to these safeguards may result in our starting / returning to a telehealth arrangement or ending sessions. I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

I have initialed to indicate that I understand and agree to these actions: _____

- I will only keep in-person appointments if I am symptom free.
- If my temperature is elevated (100 Fahrenheit or more), or if I have other symptoms of a virus, I agree to cancel the appointment or proceed using telehealth. If I wish to cancel for this reason, I won't be charged our normal cancellation fee.
- I will wait in my car or outside until the provider comes to get me before our appointment time.
- I will wash my hands or use hand sanitizer when entering the building. I accept responsibility for the risk if I choose not to wear a mask. Otherwise, I will wear a mask in all areas of the office.
- I will adhere to the safe distancing precautions in the waiting and therapy rooms. For example, I won't move chairs or sit where we have signs asking me not to sit.
- I will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands).

- I will try not to touch faces or eyes with hands. If I do, I will immediately wash my hands.
- If I am bringing a child, I will make sure that the child follows all of these sanitation and distancing protocols.
- I will take steps between appointments to minimize our exposure.
- If a resident of my home tests positive for the infection, I will immediately let the provider know and we will then [begin] resume treatment via telehealth.
- I will let my provider know as soon as possible if there are questions or concerns about my care or treatment here at Acorn Counseling PLLC.
- I have the following concerns at this time: _____

My Commitment to Minimize Exposure

My practice has taken reasonable steps to reduce the risk of spreading the virus within the office and will have posted efforts on our website and in the office. I wear a mask unless you specifically request it to be taken off and accept the risk of doing so and encourage you to do likewise. Areas are sprayed daily and/or between sessions with a disinfectant. Alcohol pads and sanitizer are available and easily accessible. Washing hands and sanitizer is required before each session. Seating and appropriate physical distancing will be practiced. Restroom soap is available. Common use areas will be sanitized after each use. Physical contact is not permitted. Tissue and trash bins are easily accessible, and trash is disposed of frequently. Touchless thermometers and UVC lights will be used when they are available.

If You or I Are Sick

I understand that my provider is committed to reasonable steps in keeping us and all our families safe from the spread of this virus. If I show up for an appointment and my provider believes that I have a fever or other symptoms, or believe I have been exposed, my provider will have to require me to leave the office immediately. We can follow up with services by telehealth as appropriate. If I test positive for the coronavirus, I will notify my provider so that you can take appropriate precautions.

Confidentiality in the Case of Infection

If I or someone whom I have contacted tested positive for the coronavirus, my provider may be required to notify local health authorities that I have been in the office. If the visit has to be reported, I accept my provider will only provide the minimum information necessary for their data collection and will not go into any details of the reason(s) for our visits. By signing this form, I am agreeing that my provider may do so without an additional signed release.

Informed Consent

This agreement supplements to the general informed consent/business agreement that we agreed to at the start of our work together. I agree that telehealth sessions will not be recorded or shared outside of the therapeutic relationship. My signature below shows that I agree to these terms and conditions.

_____ /_____

Patient Printed Name, Signature/Client Date

_____ _____

Therapist/Date