Healing Steps Counseling PLLC

Laura L. Lancaster, M.A., LPC
17480 Dallas Parkway, Suite 120
Dallas, TX 75287-7352
Office: (469) 443-8557
www.HealingStepsCounseling.com

NEW CLIENT INTAKE FORM

(Confidential)

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):
_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age:
_____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No

**Please note*: *Email correspondence is not considered to be a confidential medium of communication.*

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ Yes □ No

If Yes, please provide name and date you last saw this therapist:

Therapist Name:_____ Date: _____

MEDICATION:

Are you currently taking any prescription medication? □ Yes □ No If yes, please list.

Medication/Dosage	**Purpose**	**Prescribing Physician**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing along with the average # of hours of sleep you have a night:

_____

How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

Please list any difficulties you experience with your appetite or eating patterns:

_____

Please circle all that apply to you **currently**: (Scale from 1 – 10. 10 being the highest.)

Stressed / Overwhelmed	None	Low	1	2	3	4	5	6	7	8	9	10 highest
Depression / Sadness	None	Low	1	2	3	4	5	6	7	8	9	10 highest
Grief / Loss	None	Low	1	2	3	4	5	6	7	8	9	10 highest
Anxiety	None	Low	1	2	3	4	5	6	7	8	9	10 highest
Panic attacks	None	Low	1	2	3	4	5	6	7	8	9	10 highest
Phobia _____	None	Low	1	2	3	4	5	6	7	8	9	10 highest

Chronic Pain _____ None Low 1 2 3 4 5 6 7 8 9 10 highest

Worthless None Low 1 2 3 4 5 6 7 8 9 10 highest

Hopeless None Low 1 2 3 4 5 6 7 8 9 10 highest

Scared None Low 1 2 3 4 5 6 7 8 9 10 highest

Nightmares None Low 1 2 3 4 5 6 7 8 9 10 highest

Are you currently having any thoughts of suicide? □ Yes □ No

How strong are your thoughts? None Low 1 2 3 4 5 6 7 8 9 10 highest

Do you have a plan? □ Yes □ No

If you have a plan, explain

_____

_____

Previous suicide attempts? □ Yes □ No If yes, how many? _____

Are you currently or have you ever experienced any physical, sexual or emotional abuse? □ Yes □ No If yes, please check: □ physical □ sexual □ emotional

How old were you? _____ Did you know your perpetrator? □ Yes □ No

Briefly describe the event/s:

_____

_____

_____

SUBSTANCE USE:

How often do you drink alcohol? □ Never □ Once a week □ Occasionally □ Daily

Does drinking alcohol interfere in your daily functioning? □ Yes □ No

If Yes, do you consider yourself an alcoholic? □ Yes □ No How long? ____

How often do you engage in recreational drug use?

□ Never □ Once a week □ Occasionally □ Daily

Does your drug use interfere in your daily functioning? □ Yes □ No

If Yes, do you consider yourself addicted to drugs? □ Yes □ No

What is your drug of choice? _____

Have you ever sought treatment? □ Yes □ No

If Yes, please list the details (dates/facility): _____

Are you currently married or in a romantic relationship? □ Yes □ No

If yes, for how long? _____

On a scale from 1 -10, how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently?

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following.
If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Check		List Family Member
Alcohol Abuse	□ Yes	□ No	_____
Substance Abuse	□ Yes	□ No	_____
Anxiety / Panic	□ Yes	□ No	_____
Depression	□ Yes	□ No	_____
Domestic Violence	□ Yes	□ No	_____
Eating Disorders	□ Yes	□ No	_____
Obesity	□ Yes	□ No	_____
Obsessive Compulsive Behavior	□ Yes	□ No	_____
Schizophrenia	□ Yes	□ No	_____
Bipolar	□ Yes	□ No	_____
Suicide Attempts	□ Yes	□ No	_____

ADDITIONAL INFORMATION:

Are you currently employed? □ Yes □ No Job Title: _____

If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

Do you consider yourself to be spiritual or religious? □ Yes □ No

If yes, do you have a denomination: _____

What do you consider to be some of your strengths?

_____

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

Additional information you would like to add:

_____

_____

Personal Note – From Laura:
I look forward to working with you during your journey. This is a big step towards healing. Congratulations!

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CLIENT INFORMED CONSENT

My Philosophy: I will provide a caring, compassionate and professional counseling atmosphere to help you on your journey to healing. I am honored to help you.

Counseling Relationship: Counseling sessions will last 50 minutes for adults, families and couples. Due to attention span, minors sessions will be 30 to 45 minutes. I ask that you attend all scheduled sessions and notify me 24 hours in advance of cancellation. Emergency cancellations will be considered on a case-by-case basis. If appropriate notice is not given, then you will be charged "in full" for your missed session. Please understand that the missed appointment fee will be invoiced and mailed to your address on file and that third party payors do not pay for missed appointments.

Effects of Counseling: Counseling is a personal exploration and may lead to major changes in your life perspective and decisions. These changes may affect significant relationships, your job, and your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. I will work to achieve the best possible results for you. Some clients need only a few counseling sessions to achieve their goals while others may require months or sometimes years of counseling. You are in complete control and may end the counseling relationship at any time, though I do ask that you participate in a termination session.

Counseling Sessions: Although counseling sessions may be very intimate psychologically, it is important for you to realize that I have a professional relationship rather than a social one. Our contact will be limited to sessions you arrange with me. Please do not extend invitations to social gatherings, ask me to write references for you, or ask me to relate to you in any way other than in the professional context of our counseling sessions. You will be best served while we are seeing you for counseling if the relationship remains strictly professional and if our sessions concentrate exclusively on your concerns. For further details, please read my Social Media Policy.

Referrals: Should you and I believe that a referral is needed, some alternatives, including programs and/or professionals, will be provided to assist you. You will be responsible for contacting and evaluating those referrals and/or alternatives.

Fees: The fee for each session must be paid at the *beginning* of each session. Acceptable forms for payment are cash, all major credit cards or personal checks made payable to "Healing Steps Counseling PLLC." *There is a $40 return check policy. Invoice/receipt available upon request.*

Individual	*$100 per 50 min session*
Couples / Family	*$150 per 50 min session*
Initial Intake	*$125 per 50 min session*

Insurance Reimbursement: My services are considered "out of network". I will be happy to provide you an invoice/receipt for each session completed, available upon request. You may use this invoice/receipt to file with your insurance company. *Please remember*, health insurance companies often require diagnoses of your mental health condition and indicate that you have an "illness" before they will agree to reimburse you. In the event a diagnosis is required, I will inform you of the diagnosis. *Any diagnosis made will become a part of your permanent insurance records.*

Legal Issues (Court): I have no court experience and being master's level counselor would generally not be considered an expert witness. If you become involved in litigation that requires my participation, and due to the complexity and difficulty of legal involvement, I charge $200 per hour for preparation for and attendance at any legal proceedings. The fee for this service begins from the time I leave the office until I return to the office. Also, a $1,500 retainer will be required up front if court appearances occur.

Records and Confidentiality: Both law and standard of my profession require that I keep appropriate treatment 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 may be difficult to understand clearly. Clients will be charged an appropriate fee for any preparation time required to comply with an information request. All of our communications becomes part of the clinical records. Records are the property of Healing Steps Counseling PLLC. Client records are disposed of five years after the last session. All of our communication is confidential with the following limitations and/or exceptions: a) it is determined you are a danger to yourself or someone else; b) you disclose abuse/neglect/exploitations of a child, elderly, or disabled person; c) you disclose inappropriate behavior by another mental health professional; d) a court orders the disclosure of client information; e) you direct us to release your records to another professional; f) we are otherwise required by law to disclose information.

IMPORTANT:
If your counselor encounters you in public, s/he will maintain your confidentiality by acknowledging you only if you approach first.

By your signature/signatures below, you are indicating that you have read and understand this consent form, and/or that any questions you have about this statement were answered to your satisfaction.

Print Name: _____

Signature: _____ Date: _____
(Client / Guardian of Minor)

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

(PRINT) Client Name: _____

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Client Signature **(Client's Parent/Guardian if under 18)** **Today's Date**

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Client's name: _____
First Name Middle Name Last Name

2. Date of Birth: ___/___/___

3. Date authorization initiated: ___/___/___

4. Authorization initiated by:

_____
Name (client, provider, or other)

5. Information to be released:

¨ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

¨ Other (describe information in detail):
_____

6. Purpose of Disclosure: The reason I am authorizing release is:

¨ My request ¨ Other (describe): _____

7. Person(s) Authorized to Make the Disclosure:

_____

8. Person(s) Authorized to Receive the Disclosure:

_____

9. This Authorization will expire on ___/___/___ or upon the happening of the following event:

_____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of the Patient:

_____

Signature of Personal Representative:

_____

Relationship to Patient if Personal Representative:

_____

Date of signature: _____

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes***. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. <u>Such authorization must be separate from an authorization to release other medical records</u>.

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CANCELLATION POLICY

If you fail to cancel a scheduled appointment, I cannot use this time for another client and you will be billed for the full cost of your missed appointment.

I acknowledge a full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment. If you have a credit card on file, the credit card will be billed for the appropriate session amount.

Thank you for your consideration regarding this important matter.

PRINT Client Name: _____

_____

Client Signature **(Client's Parent/Guardian if under 18)** **Date**