ADULT INTAKE FORM

Date _____

Client Name _____ Date of Birth ___/___/____ Sex: M / F

Marital Status: _____Single _____ Married _____ Separated _____ Divorced _____Widowed

Spouse's Name _____ (if applicable)

Client Address _____

City/State/Zip _____

Cell number: _____ May we leave a voicemail or text your cell? _____Yes _____ No

Email: _____ May we contact you by email? ____Yes_____No

I understand that communication by voicemail, text or email cannot be guaranteed private and confidential. I agree to the risks when communicating in these ways with my counselor.
_____ Yes _____ No

Rate your current physical health: _____ Very Good _____ Good _____ Average _____ Declining

Are you under the care of a medical doctor? _____Yes _____No
If yes, please list name and number of doctor: _____

Are you taking any prescription medication? _____Yes _____No
If yes, please list the name, amount, and frequency: _____
_____
_____
Is your prescription medication usage a concern of yours or of someone close to you? _____Yes _____No

Do you drink alcohol? _____Yes _____No
If yes, please list type, amount and frequency: _____
_____
Is your alcohol consumption a concern of yours or of someone close to you? _____Yes _____No

Do you use any type of illegal drugs? _____Yes _____No
If yes, please list type, amount and frequency: _____
_____
Is your drug use a concern of yours or of someone close to you? _____Yes _____No

Have you ever seen a counselor before? ____ Yes ____ No
If yes, please name whom, when, and the outcome:
_____
_____

Have you ever received inpatient treatment before? _____ Yes _____ No
If yes, please name where, when and the diagnosis/outcome:
_____
_____

What is your reason for seeking counseling at this time?
_____
_____

Please list any religious/spiritual or cultural information about you or your family that is important for me to know. I am very interested in understanding how your religious/spiritual or cultural beliefs are influencing you/us as we continue to work together.
_____
_____
_____

Name of person(s) to contact in the event of an emergency:

1. _____
   (relationship)_____
   (phone #)_____

2. _____
   (relationship)_____
   (phone #)_____

INFORMED CONSENT AND PRACTICE POLICIES

I agree to take part in treatment with an **Elledge Counseling Associates (ECA)** counselor. I understand that developing a treatment plan with my counselor and working toward those goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment.

I am aware that I may stop treatment at any time, however, I am also aware that many times clients may feel like stopping therapy due to the pain or discomfort of addressing issues that are important to their well-being. Therefore, I agree to talk with my counselor if I feel like ending therapy before all my treatment goals are met.

Sessions last for 45 minutes. I understand that if I am late to an appointment the counselor will not run over into another client's appointment and I will be billed for the entire session fee.

I understand that no unsupervised children are allowed in the building during sessions. If I am unable to find childcare, I agree to cancel my session at least 24 hours before the appointment to avoid a late cancellation fee.

Confidentiality is the ethical right of all clients. However, there are certain exceptions when your therapist may be ethically bound and legally required to share information with the proper authorities.

Exceptions to Confidentiality:

1. The therapist assesses that the client is a danger to self or others.
2. A client reports past or present abuse/neglect/exploitation of a child, elderly person, or a person with a disability (physical or intellectual).
3. A client acknowledges committing present or past abuse/neglect/exploitation of a child, elderly person, or a person with a disability (physical or intellectual).
4. When counseling records are subpoenaed by a court of law.
5. A client shares with the counselor their use of pornography involving minors.

By signing below, you are stating that you have read and understood this Informed Consent and Policy Statement, and have had any questions about this document answered to your satisfaction.

Client Printed Name _____ Date _____

Client Signature _____

LEGAL REQUESTS/COURT PROCEEDINGS

If I, my legal counsel, or an adversarial counsel subpoenas any counselor from ECA to appear on my behalf, in a deposition or any court proceeding, I agree to pay that counselor $1500.00 per day to appear in court cases within the same county of the counselor's primary office location. If the counselor is required to travel outside their county or stay overnight, an additional full day rate will be charged.

I also understand that the counselor will require a subpoena to appear. An email subpoena is acceptable.

I also understand that the court appearance fee is due 72 hours in advance of my appearance, and if that fee is not paid as required, the counselor will seek legal representation to file a motion to quash the subpoena.

If the court appearance is canceled with a minimum of 48 hours advance notice, $1000.00 may be refunded to you. This is not a guarantee. Despite cancellation, payment processing fees, the counselor's legal fees, and the counselor's time spent in court preparation is an expense.

If I or my legal counsel requests a copy of the client file, session notes, treatment summaries or session attendance documentation on my behalf, I agree to pay all reasonable copying and or postage costs. Clients may pick up the documents or pay to have the documents mailed to them. All payments must be processed before the documents are presented.

ECA counselors are not expert witnesses nor custody evaluators. We cannot give legal advice so we strongly urge clients to discuss with their lawyers the perceived need for a counselor's documentation or court testimony, and the subsequent financial burden it may cause the client.

By signing below, you are stating that you have read and understood this policy statement and have had any questions about this document answered to your satisfaction.

Client Printed Name _____ Date _____

Parent/Guardian Signature _____

FEE ACCOUNTABILITY AND FINANCIAL CONSENT

I am aware that I must cancel a scheduled appointment with at least 24 hours' notice to avoid financial responsibility for that session. It is my responsibility to call or text my counselor (day/night/weekend) to cancel my appointment.

I agree to the one-time charge or debit to my credit/debit card in the amount of my regular fee if I fail to cancel an appointment with less than 24 hours' notice. Elledge Counseling Associates is not required to notify me of this charge.

I am aware that payment is due at the beginning of each session. All checks should be made out to **ECA**. If paying by cash, I will bring the exact amount. Counselors are unable to make change and the excess will be applied to my next session. I understand that if I choose to pay ahead for sessions, no refunds will be made for unused sessions.

If my check is returned for insufficient funds I agree to a one-time credit/debit charge to my card/account plus the NSF fee and a service charge. Elledge Counseling Associates is not required to notify me of this charge.

If I do not return books/CD/DVD material(s) to my ECA counselor, I agree to the one-time charge or debit to my credit card/account in the amount of the replacement cost of the material(s) and credit card service fee. Elledge Counseling Associates is not required to notify me of this charge.

If I request diagnosis information, treatment summaries or session attendance documentation, for insurance reimbursement, I agree to pay my counselor's regular session fee per hour to copy, complete, or mail the requested materials. All payments must be processed before the documents are presented. There is *no charge* for providing you with a standard receipt of sessions attended for tax purposes.

I understand that my counselor is unable to make further appointments with me until any balance on my account is paid in full.

Credit /Debit Card Information:

Name as it appears on the card_____
Credit/Debit Card #_____
Expiration Date_____
Security Code _____
Cardholder's Zip Code _____

_____ _____
Cardholder Signature Date

LIMITS OF THE COUNSELING RELATIONSHIP

It's important to remember that although the sessions with the counselor may feel very intimate emotionally or psychologically, the counseling relationship is a professional one and not a social one.

The counseling relationship is governed by certain laws (Texas Administrative Code, Title 22, Part 30, Chapter 681) and ethics (Subchapter C) that are set in place **for the protection of the client**.

For example:

1. Contact must be limited to sessions you schedule with the counselor.

2. Due to ethical guidelines, please do not to invite your counselor to social gatherings, offer gifts, ask your counselor to write references or relate to you in any way other than the professional context of the counseling sessions (**this includes any interaction involving social networking sites, i.e., Facebook, Instagram, LinkedIn, dating apps, etc.**).

3. Your counselor is required to keep the identity of clients confidential. Therefore, your counselor cannot, and will not, acknowledge you outside of counseling sessions unless you first acknowledge them.

4. When the counseling relationship ends, the limitations of contact with the counselor must remain the same.

If you feel that your therapist has failed to adhere to the laws or ethics governing Texas LPCs please address this with your counselor or the Executive Director of ECA. Or you may file a complaint by writing or calling the Texas Behavioral Health Executive Council at 333 Guadalupe St., Ste. 3-900 Austin, Texas 78701, (512) 305-7700. Or you may download a complaint form from the website at https://www.bhec.texas.gov/wp-content/uploads/2020/07/BHEC-Complaint-Form.pdf.

My signature below affirms that I have read, understood, and agree to the limits of the counseling relationship.

_____ _____

Client Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by The Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by the practice, and of your individual rights and the practice's legal duties with respect to confidential information.

Ways in Which We May Use and Disclose your Protected Health Information:

We may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment and healthcare operations.

- **Treatment** means providing, coordinating, or managing mental health care and related services. *For example* – use or disclosure by the health care provider in training programs in which "students, trainees, or practitioners in mental health" learn under supervision to practice or improve their skills in group, joint, family, or individual counseling. <u>This also means, that unless you request otherwise, ECA counselors may consult with one another to coordinate care; in your case alone or in the case that a family member is also working with an ECA therapist.</u>

- **Payment** means activities such as obtaining payment for the mental health care services we provide for you either from your insurance or another third-party payer, credit card or collection agency. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, and procedures performed in an attempt to collect payment.

- **Health care operations** include the business aspects of running our practice. *For example* – to evaluate our treatment and services, or to evaluate our staff's performance while caring for you. We may at times communicate with you by text or email; both of which may not always be a secure form of communication. You may refuse this kind of communication by checking the appropriate box on your intake form.

We may contact you to provide appointment reminders or other services that may be of interest to you. We will disclose your protected health information to any person *you identify* that is involved in your care or payment for your care. For example - a family member, relative, close friend, a pastor or pastor's representative whom you have asked us to communicate with.

We will use and disclose your protected health information *when required to by federal, state, or local law*. There are certain situations in which, as a therapist, I am required by ethical standards to reveal information obtained during therapy to other persons or agencies - even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or are ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke an authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Continued on next page …

NOTICE OF PRIVACY PRACTICES CON'T

Your Health Information Rights:
Although your records are the physical property of **Elledge Counseling Associates**, the information belongs to you. You have the following rights, which you can exercise by presenting a written request to our office manager.

You have:

- The right to request restrictions on certain uses and disclosures of your information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. For example – a request that we not identify the agency when we contact you.
- The right to inspect and copy the information that we maintain about you. However, we ***may deny an individual access***, provided that the individual is given a right to have such denials reviewed, in the following circumstances:

  1. a health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to ***endanger the life or physical safety of the individual or another person***;

  2. the information makes ***reference to another person*** (unless the other person is a health care provider) and the health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

  3. the request for access is made by the individual's personal representative and the health care provider has determined, in the exercise of professional judgment, that the provision of access to the personal representative is reasonably likely to ***cause substantial harm to the individual or another person***.
- The right to inspect or copy your information. To do so, you must submit your request in writing to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.
- The right to billing records.
- The right to revoke your consent to release information except to the extent that the agency has taken actions by way of the previously signed consent form.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. For example – at your scheduled appointment, by e-mail, or fax.
- The right to amend your information if you feel that it is incomplete or inaccurate. You must make this request in writing to your therapist stating exactly what information is incomplete or inaccurate and your reasoning to support your request. We will respond to your request with in sixty (60) days. In rare cases your request may be denied. For a complete description of Rights of Amendment, please contact our office manager.
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request.
- The right to file a complaint if you believe we have violated your medical information privacy rights. You have the right to file a written complaint to our office manager, or Executive Director, or directly to the Secretary of Health and Human Services

To file a complaint with our practice, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Brenda Elledge, Director, **Elledge Counseling Associates 328 Pebblebrook**, Red Oak, TX 75154. You should know there will be no retaliation for your filing a complaint.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. If and when one is available, you may request a written copy of a revised notice from this office.

I am aware of the uses, disclosures, and my individual rights regarding my confidential information. _____ (Initial)