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This packet will include:

* Intake Form
* Informed Consent & Practice Policies
* Telehealth Informed Consent
* Privacy Practices/HIPAA
* Credit Card Information & Signature Page
1. Please save a copy of this packet to keep for your own records.
2. You can choose to bring the signed paper copy to your first session or electronically fill it out and send it to your counselor’s HIPAA secure email.
3. If you choose to send the packet to your therapist via their HIPAA secure email you are confirming all typed signatures and initials represents your legal handwritten signature.

 We look forward to meeting you at your first appointment!

#  ADULT INTAKE FORM

Date Click or tap to enter a date.

**Client Name** Click or tap here to enter text.

Date of Birth Click or tap to enter a date. Sex: Choose an item.

Marital Status: Choose an item.

Spouse or Partner’s Name: Click or tap here to enter text.

Client Address: Click or tap here to enter text.

City/State/Zip: Click or tap here to enter text.

Cell number: Click or tap here to enter text.

May we text you or leave a voicemail? Choose an item.

Email: Click or tap here to enter text.

May we contact you by email? Choose an item.

**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.**

Choose an item.

Rate your current physical health: Choose an item.

Are you taking any prescription medication? Choose an item.

If yes, please list the name, dosage, and it’s intended purpose (example: Prozac 20mg -depression):Click or tap here to enter text.

Is your prescription medication usage a concern of yours or of someone close to you? Choose an item.

Do you drink alcohol? Choose an item.

If yes, please list type, amount, and frequency: Click or tap here to enter text.

Is your alcohol consumption a concern of yours or of someone close to you? Choose an item.

Do you use any type of illegal drugs? Choose an item.

If yes, please list type, amount, and frequency:Click or tap here to enter text.

Is your drug use a concern of yours or of someone close to you? Choose an item.

Have you ever seen a counselor before? Choose an item.

If yes, please name whom, when, and the outcome: Click or tap here to enter text.

Have you ever received inpatient treatment before? Choose an item.

If yes, please name where, when and the diagnosis/outcome: Click or tap here to enter text.

What is your reason for seeking counseling at this time? Click or tap here to enter text.

If you would like to share any religious/spiritual or cultural information about you or your family that is important for me to know please feel free to do so. Or you can always share information with me in session as we go along. I am very interested in understanding any religious/spiritual or cultural beliefs that may influence you and me as we continue to work together. Click or tap here to enter text.

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

|  |  |
| --- | --- |
| 1. Click or tap here to enter text. |  2. Click or tap here to enter text. |
|  (relationship)Click or tap here to enter text. |  (relationship) Click or tap here to enter text. |
|  (phone #)Click or tap here to enter text.  |  (phone #)Click or tap here to enter text.  |

**INFORMED CONSENT AND PRACTICE POLICIES**

**Treatment**

I agree to take part in treatment with an **Elledge Counseling Associates (ECA)** counselor. Treatment may include interpersonal, cognitive-behavioral, psychodynamic, and/or affective methods to achieve my goals.

* I understand that making a treatment plan with my counselor and working toward those goals are in my best interest.
* I understand my counselor will give me feedback and treatment options based on their education, training, and experience but I have the final say in my treatment.
* I understand that no promises have been made to me as to the results of treatment.

I may stop treatment at any time; however, I will keep in mind that addressing some issues will likely be painful or uncomfortable and I may feel like stopping therapy to avoid the pain or discomfort.

* I agree to talk with my counselor if I feel like ending therapy before all my treatment goals are met.

**Confidentiality**

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.

 Possible Exceptions to Confidentiality:

1. The therapist assesses that you are a danger to yourself or others.

2. You report past or present abuse/neglect/exploitation of any child, elderly person, or a person with a disability (physical or intellectual).

* This may include reporting abuse that happened to you as a minor.
* Reports can be made keeping your name anonymous.

3. You acknowledge 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. You disclose your use of pornography involving minors.

**The Client/Counselor 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 the scheduled sessions only.
	* Texts or emails are for the purpose of appointment scheduling only.
	* Texts or calls outside of session are for emergency purposes only.
2. Due to ethical guidelines, please do not to invite your counselor to social gatherings, offer them expensive gifts, or ask your counselor to write references for you.
3. Please do not attempt to connect with your counselor through **social networking sites, i.e., Facebook, Instagram, LinkedIn, dating apps, etc.**).
4. 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.
5. When the counseling relationship ends, the limitations of contact with the counselor must remain the same. The Texas LPC Code has strict boundaries on these matters.

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/discipline-and-complaints/index.html> or call Investigations/Complaints 24-hour line at (800) 821-3205.

**Legal Requests/Court Proceedings**

If I, or my legal counsel, or an adversarial counsel subpoenas my counselor or 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.
* The counselor will require a subpoena to appear. An email subpoena is acceptable.
* The court appearance fee is due 72 hours in advance of 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.

* This is not a guarantee.
* The counselor’s legal fees, and the time spent in court preparation is a billable 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 postage costs.

* All payments must be processed before the documents are presented.
* Please allow two weeks to process requests for documents.

**Texas LPCs may not offer an expert opinion or recommendation relating to the conservatorship of, or possession of, or access to a child according to** Texas Administrative Code (Title 22, Part 30, Chapter 681), and ethics (Subchapter C).

**Unaccompanied Minors**

I understand that no unsupervised children are allowed in the buildings during sessions.

* Unaccompanied minors are not allowed to wait unsupervised while their parent(s) are in session.
* 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.

**Client Files & Records Requests**

I may request a copy of my file at any time from my therapist and I agree to pay all reasonable copying/scanning, and/or postage costs.

* All payments must be processed before the documents are presented.
* Please allow at least two weeks for requests to be fulfilled.
* Client files will be kept for a minimum of seven (7) years from the date of termination of services with the client, or five (5) years after the client reaches the age of majority (18), whichever is greater.
* Each therapist has a plan in place for the security, storage, and disposal of your records. Please feel free to ask them about these procedures.

**Fees & Financial Agreements**

I have agreed to the cost of the session. Sessions last 45 minutes.

* I understand that if I am late to my appointment the counselor will not run over into another client’s appointment and I will be billed for the entire session fee.
* I agree to call or text my counselor 24 hours before my scheduled appointment to avoid a no-show or late cancellation charge.
* 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 understand that I will not be able to resume sessions until all no-show/late cancellation fees are paid.

I am aware that payment is due at the beginning of each session.

* Payment may be made by cash, check, credit card or HSA card.
* Checks should be made out to **ECA**.
* If paying by cash, please bring the exact amount. Counselors are unable to make change and any excess will be applied to the 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.

**Insurance/Tax Documentation**

There is *no charge* for a standard receipt of sessions attended. If I request a “Superbill” or HCFA 1500 form which includes a diagnosis, and session dates for out-of-pocket insurance reimbursement I agree to pay my counselor’s regular session fee per hour to prepare, scan, or mail the requested materials.

* All payments must be processed before the documents are presented.
* Please allow two weeks for processing all requests.

**Emergency Protocol**

Elledge Counseling Associates is not equipped to offer urgent-care availability in the event of a mental health emergency. You may call or text your therapist in the event of a mental or emotional health emergency but your therapist may not be able to respond to you immediately. Please allow at least 24 hours for them to respond and on weekends your therapist may not respond until Monday.

ECA therapists work with their clients in session to prepare them to cope with difficult stressors, crisis situations, and to maintain personal safety. Each client’s individual need will be considered.

This preparation might include:

* Increasing positive coping skills
* Building a safe support system
* Creating a personalized safety plan

**In the event of a life-threatening mental health emergency please follow this Safety Plan:**

* Call the North Texas Behavioral Mobile Response Team (to schedule an evaluation at your home w/in 24hours) 866-260-8000
* Call 911 (for immediate response)
* Go to the nearest Behavioral Health Hospital (google Behavioral Health near me)
* Call the National Suicide & Crisis line (800) 273-TALK
* Text the Suicide text line at 741-741

**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. 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.
* **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.

 **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. 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 one is available, you may request a written copy of a revised notice from this office.

For more information about HIPAA or to file a complaint: (202) 619-0257 Toll Free: 1-877-696-6775

The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

**Good Faith Estimate Disclaimer**

You are entitled to receive a *Good Faith Estimate* of the expected charges for your services at Elledge Counseling Associates. On Dec. 27, 2020, the No Surprises Act (NSA) was signed into law as part of the Consolidated Appropriations Act of 2021. These provisions were intended to address unexpected gaps in insurance coverage that result in “surprise medical bills” when patients unknowingly obtain medical services from physicians and other providers outside their health insurance network.

Elledge Counseling Associates takes payment at the time services are rendered so there will never be “surprise medical bills” from ECA. However, in compliance with the No Surprises Act (NSA), we are providing you with an estimate of possible charges.

*This Good Faith Estimate* shows the costs of items and services that may occur in pursuit of your health care needs. The estimate is based on information known at the time the estimate was created; prior to the first session with your chosen counselor.

*The Good Faith Estimate* does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more, and get a form to start the process, go to [www.cms.gov/nosurprises/consumers or call 1-800-985-3059](http://www.cms.gov/nosurprises/consumers%20or%20call%201-800-985-3059).

**Good Faith Estimate for Mental Health Care Services**

**Therapist Name:** Click or tap here to enter text.

Elledge Counseling Associates National Provider Identifier # 1356881668

Taxpayer Identification # 20-0920005

**Details of Services:**Services Requested/Scheduled – 45-minute counseling /psychotherapy sessions

Patient Diagnosis (if known): Click or tap here to enter text.
Date of initial appointment: Click or tap to enter a date.

**Expected Charges:**

Session fee $ Click or tap here to enter text.

**Other possible charges:**

Late Cancellation/No Show fee: (same as session fee) Click or tap here to enter text.

Court/Deposition Appearance - $1,500.00

Court/Deposition Appearance – Out of County/overnight stay: $ 3,000.00

Completing Legal Documents or Insurance Receipt fee: session fee/per hour

***Your actual total cost* will depend on the number of sessions you attend**.

*The Good Faith estimated costs are valid for 12 months from the date of the Good Faith Estimate.*

Estimated Total Cost $: Click or tap here to enter text. (Calculate this based on a weekly appt for 12 months).

Date of Good Faith Estimate: Click or tap to enter a date.

The Good Faith Estimate is NOT a contract. It is for your information purposes only.

**TELEHEALTH INFORMED CONSENT\***

*\*In-person clients may choose to sign this form as a back-up in the event of unforeseen circumstances that may make it difficult to attend a scheduled in-office appointment.*

**Telehealth Counseling Options Offered:** I understand that my counselor may offer counseling via phone and visual telecommunication (online). Online sessions are only offered through a HIPAA compliant platform. There are no HIPAA compliant phone platforms.

**Client Privacy/Client Safety:** There is always a potential, albeit small, risk of compromise to confidentiality by using phone or visual communication

* For privacy purposes, I agree to hold sessions in a secure environment, with minimal distractions, and no one else in the room.
* For safety purposes, I will not try to hold sessions in the car while driving.
* For safety purposes, my counselor will confirm my identity and location at the beginning of each telehealth session.

**Technology Failure:** I understand that in the event of a technology failure during a phone or online session, immediate steps will be taken **by the therapist** to reconnect. Contact via the same method used before disconnection will be tried first, followed by text messaging. If calls or texts fail, email is the next backup step to failed phone and online reconnection. **The therapist** will repeatedly attempt to use these methods to contact me through the remaining session time. If reconnection is unable to be made within 10 minutes, depending on the time contact was lost, the compromised appointment will be terminated and may be billed at the full rate.

**Ethics/Laws:** Elledge Counseling Associates follows the laws and professional regulations in the State of Texas and therefore, ECA counselors are only authorized to offer telehealth sessions to clients in Texas.

**Please confirm your choice below.**

[ ] I reside in the State of Texas and I consent to telehealth counseling usinga HIPAA secure online platform only.

[ ]  I reside in the State of Texas and I consent to telehealth counseling usinga HIPAA secure online platform and/or a non-HIPAA secure phone call.

[ ]  I decline all telehealth services. I will only attend sessions in person.

**Signature Page**

**Credit Card Information**

A current card is required on file to book future appointments. Your information is secure. If you decline to place a card on file, you may pay ahead for several sessions at your first appointment to hold future appointments. Reminder – any prepaid sessions will not be refunded if unused.

Name as it appears on the card Click or tap here to enter text.

Credit/Debit Card # Click or tap here to enter text.

Expiration Date Click or tap to enter a date.

Security Code Click or tap here to enter text.

Cardholder’s Zip Code Click or tap here to enter text.

**By signing or typing my signature below, I confirm I am the cardholder or have permission from the cardholder to provide ECA with this information and give consent to charge.**

**By signing or typing my signature below, I confirm I have read, understood, and agreed to all the Practice Policies provided to me in this packet and give informed consent.**

Client Printed Name Click or tap here to enter text. Date Click or tap here to enter text.

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_