BRIEF INTAKE INFORMATION & MEDICAL/PSYCHIATRIC HISTORY

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Client Name: _____ Social Security # _____

Birthday: _____ Age: _____ Gender: _____ Marital Status: _____

Street Address: _____

City, State, Zip: _____

Hm. Ph.: _____ Cell Ph.: _____ Wk. Ph.: _____

Email: _____

Preferred Method of Contact: _____

Highest level of education: _____ Name of school attended: _____

Developmental History (ie, complications at birth, delays in school) (if minor):

_____

Educational History: _____

Current School or Employer & Job Title: _____

Emergency Contact Name and Number: _____

Relationship to you: _____

May we call you at home? Leave a message? May we call you at work? _____

PERSON RESPONSIBLE FOR ACCOUNT (If other than client) Relationship to Client: _____

Name, Address & Phone: _____

_____

INSURANCE INFORMATION

Name of Policy Holder: _____ DOB/SS#: _____

Address, City, & Zip: _____ Phone: _____

Policy Name and Number: _____ Employer: _____

REFERRAL SOURCE _____

MEDICAL & PSYCHIATRIC HISTORY

Client Primary Care Physician Name & Number: _____

Date of last medical exam: _____

Allergies: _____

List any prescription/over the counter drugs you currently take:

_____

Describe any history of medical conditions, hospitalizations or surgeries:

_____

Please mark any area(s) for which you **currently** or **previously** had **problems or concerns**: ☐ Anxiety ☐ Depression ☐ Behavioral ☐ Marriage ☐ Substance Abuse ☐ Stress ☐ Anger Management ☐ Suicidal Ideation/Prior Attempts ☐ Anger ☐ Other:

Describe and give any current or past history of counseling, psychotherapy, or inpatient mental health treatment:

_____

History of substance use:

Cigarettes: _____ How long? _____ How Often? _____

Alcohol: _____ How long? _____ How Often? _____

Illicit drugs: _____ How long? _____ How Often? _____

Family History of Substance Abuse: (mark all that apply): ☐ Mother Maternal: ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ Siblings ☐ Father Paternal: ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ Other:

_____

Family history of mental health conditions? No yes, please explain:

_____

_____

BACKGROUND HISTORY:
Describe any traumatic life events:

_____

_____

Physical, emotional and/or sexual abuse history:

_____

_____

Describe your family status and support network (community, church, friends, etc.

_____

Briefly share your employment history, including any military service:

_____

Why have you decided to seek counseling?

_____

_____

_____

What goals do you hope to accomplish?

_____

_____

Other information you would like the counselor to know:

_____

_____

_____ _____

Client Signature & Date *Legal Representative & Date*

INFORMED CONSENT TO MENTAL HEALTH SERVICES & CLIENT RIGHTS

Desiree Rice, MEd, LPC • 3560 Delaware, Suite 1205, Beaumont, TX 77706 • ph. (409) 338-9003/f. (800) 842-3210
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Therapy is a joint effort between the therapist and the client, the result of which cannot be guaranteed. Progress depends on many factors, including motivation, effort and other life circumstances such as interactions with family, friends and other associates. The relationship between the therapist and client is the basis of the help that can be obtained in therapy. The following rights and responsibilities are offered as a foundation for the therapeutic relationship.

Client Rights & Confidentiality: All information disclosed within sessions is confidential and may not be revealed to anyone without your written permission except where disclosure is required by law or is a condition for reimbursement. For a minor, the custodial parent will have to sign the release of information. I will inform you whether or not I believe releasing that information might be harmful to you in any way. Individual therapy with children or adolescents requires special consideration in that the client's legal guardians may rightfully inquire about any treatment information; however, for the greater good of the youth, I request that parents/guardians be sensitive to the privacy that is needed for their youth to benefit from therapy. I may discuss general progress in treatment, but most information will remain confidential between me and your child. Disclosure may be required without your permission in the following circumstances: where there is a reasonable suspicion of child abuse or elder adult physical abuse, where there is a reasonable suspicion that the client presents a danger of violence to others, or where the client is likely to harm him/herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding such as therapy or evaluation by order of a court of law or in response to a legitimate subpoena.

Treatment Issues: A plan of treatment will be developed and this treatment plan will be discussed with you. You have the right to review or receive a summary of your records at any time, except in limited legal or emergency situations. You have the right to ask questions about any of the procedures used in the course of your therapy or evaluation. You have the right to terminate the therapy or evaluation with the provider at any time without any financial, legal, or moral obligations other than those you have already incurred prior to termination. I will provide you with the names of other qualified professionals whose services you might prefer. Because of the nature of therapy, you may experience emotional strains and make life changes, which could be distressing. Telephone calls are primarily for scheduling appointments. Important therapeutic concerns should be brought into the session so they may be given the careful attention they deserve.

Emergency Procedure: If an emergency situation arises, please leave a message; please note that phone calls are generally not retuned on weekends or after business hours in the evening. Your call will be returned only when the counselor is out of session. Please state that your call is an emergency, and only do so with a true emergency. Otherwise please go to the nearest emergency room.

Payment & Cancellations*:* Clients are expected to pay for services at the time they are rendered. Overdue accounts will be turned over to a collection agency. I understand that I will be responsible for court costs and legal fees necessary to collect on my bill. There will be a $25.00 fee for checks drawn on uncollectible funds. Sessions are generally 45-50 minutes long and billed at **$125.00 per session**. Since the scheduling of an appointment involves the reservation of time specifically for you and may involve holding appointments for other clients, a **minimum of 24-hours' notice is required to reschedule or cancel an appointment**. Without adequate cancellation, the full fee may be charged directly to you for missed sessions without notification. _____ **(Please Initial)** We also reserve the right to discharge you as a client if you "**no show**" or "**same-day cancel**", two or more times.

Consent to Evaluation & Treatment
After reading and understanding the rights and responsibilities above, I authorize, Desiree Rice, M.Ed, LPC, to carry out psychological examination and treatment procedures on myself and/or my child which now, or during the course of care, are advisable and for which I am legally responsible.

_____ _____
Client's Signature & Date Therapist's Signature & Date

_____ _____
Parent or Legal Representative & Date Other Signature (optional)

HIPPA, PRIVACY PRACTICES & RELEASE OF INFORMATION

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REQUIRED: HIPPA & Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

At your request, we will provide you with a copy of the Health Information Privacy Policy Act (HIPPA)

I have received, read and understand your Notice of Privacy Practices (NPP) containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its NPP from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the NPP; I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

_____ _____
Client's Name - Printed Parent or Legal Representative & Date

_____ _____
Client's Signature & Date Other Signature (optional)

OFFICE USE ONLY
I attempted to obtain client's signature in acknowledgment on the NPP Acknowledgment, but was unable to do so as documented below:
_____ Individual refused to sign
_____ Communication barrier prohibited obtaining the acknowledgment
_____ An emergency situation prevented me from obtaining acknowledgment
_____ Other (please specify) _____

OPTIONAL: Release of Information for Continuum of Care & Treatment

This section should be completed if you want another counselor, psychiatrist, your primary care physician, or other healthcare professional to provide me with confidential medical, psychological, psychiatric, educational, and/or other appropriate information about you. This authorization shall be effective from the date of signing, unless otherwise noted.

PERSONS OR AGENCIES (Please initial each one to the right)

_____ _____

_____ _____

THIS IS A (Please choose one)
□**Two-way release** of information, so that Desiree Rice and the persons or agencies listed above may communicate with each other and share information about my child or client.
□**One-way release** of information, so that Desiree Rice may share information about my child or client with the persons or agencies listed above.

_____ _____
Client's Name - Printed Parent or Legal Representative & Date

_____ _____
Client's Signature & Date Other Signature (optional)

COMPLAINTS ABOUT THIS COUNSELOR MAY BE REPORTED TO:
TX DEPT OF STATE HEALTH SERVICES @ 1100 W. 49TH STREET AUSTIN, TX or 1.800.832.9623

EXPANDED INFORMED CONSENT

- **Logistics:** Duration of appointments is between 30 – 60 minutes, whereas a full session is typically 45-50 minutes, location, frequency, protocol for making, changing, and canceling appointments.

- **Payment Options and Specifications:** Client is responsible for insurance and no show appointments; no cash refunds unless billing error from counselor's office.

- **Referrals:** Given upon request/needed. Will always give at least 3 referral sources.

- **Client Responsibilities:** Notify counselor if fearful, anxious, confused, feeling or experiencing uncomfortable emotion or thought.

- **Unlocked doors:** The client may leave at any time if feeling unsafe, insecure, fearful or uncomfortable.

- **Effectiveness:** Not all counselors/counseling are effective for all clients. Please inform counselor if personalities, modalities, techniques or competence level is not what you seek. Referrals will be given at that time.

- **Non malfeasance:** Not to re-experience any trauma; to cause no harm

- **Trust/Confidentiality:** The only 2 times that confidence will be broken:
  1. If client presents a risk to self or others
  2. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or protective services to the President or other important officials.

  By current law, we cannot reveal when we have disclosed such information to the government.

  The counselor will assist the client with sharing personal information themselves in session.

- **Accessing Resources Training:** Baptist Behavioral Health, 911, Spindletop, other practitioners, emergency services, 211

- **CPS/APS/Emergency Personnel/Law Enforcement:** Reports will be submitted by practitioner at his discretion and according to state law/licensure. Practitioner will not report to client or family if report has been filed.

- **No-Shows:** Client or responsible party is required to cancel appointment at least 24 hours before appointment. Barring contractual restriction between counselor and the insurance provider, if one exists, the client/responsible party will be charged the full fee if no 24 hour notification is delivered to the counselor's office.

- **Public Interaction:** Counselor will not acknowledge or engage client or family in public unless the client/family approaches the counselor.

* I am here to provide counseling services largely based in cognitive-behavioral theories, as well as individual and interpersonal theories. My goal is to provide effective, grounded therapy. Spiritual or religious themes will only be addressed after the client has given permission.