Registration Information for DeeAnn L. Paul, LPC

Bring this completed form to 1st appointment

Basic information Today's date: _____

Name: _____

Address: _____ City: _____ ST: _____ Zip: _____

Birthdate: _____ Gender: F M

Relationship Status: Single Married Domestic Partner Divorced Widowed Separated Other

Employer: _____ Position / Title: _____

Cell phone: _____ *May I contact you or leave messages for you at this number?* ☐*Yes* ☐*No*

Home phone: _____ *May I contact you or leave messages for you at this number?* ☐*Yes* ☐*No*

Email address: _____ *May I contact you by email if necessary?* ☐*Yes* ☐*No*

Mental Health insurance: _____ ID Number: _____

Spouse / Partner Name: _____ Birthdate: _____

Spouse / Partner Employer: _____ Phone: _____

In case of emergency, please notify: _____ Phone: _____ Relationship: _____

X Signature: _____

Counseling background

Have you had counseling before? If so, when? _____ For what? _____

Have you ever been hospitalized for emotional or psychological reasons? If so, when? _____

Medications

Drug: _____ Reason for taking: _____
Drug: _____ Reason for taking: _____
Drug: _____ Reason for taking: _____
Drug: _____ Reason for taking: _____
Drug: _____ Reason for taking: _____

Primary Care Physician: _____Phone_____

Psychiatrist: _____Phone_____

Family members & other important people in your life

First Name	Relationship	Sex	Age	Occupation

What are your goals for therapy? _____

_____

_____

Policies, Procedures and Consent to Treatment

I'm glad to be working with you. I find that providing information about the therapeutic process fosters mutual trust and openness necessary for effective work. The following are guidelines for how we can best work together. I welcome any questions and feedback throughout our time together. I view therapy as a collaborative process, where we will work together to establish goals. While particular results cannot be guaranteed from therapy, your satisfaction with the process is of primary importance.
I pledge to provide services in a professional manner consistent with the ethical standards of the Texas State Board of Examiners of Professional Counselors. You are encouraged to bring any concerns to my attention so that I may work with you to resolve them in a therapeutic manner. If I am unable to resolve your concerns, you may contact the **Texas State Board of Examiners of Professional Counselors at 1-800-942-5540** or **www.dshs.state.tx.us/counselor**

APPOINTMENTS: Appointments are generally scheduled on a weekly basis or at the frequency that is best for you and your situation. Appointments are 45-51 minutes in length unless otherwise noted. Please make every effort to arrive to your appointments on time. If you arrive late, it is unlikely that I can provide you with a full length session. You, as the client, and I, as the therapist, have the right to cancel and/or reschedule appointments as necessary. **Please note that a 24-hour advance notice is required for cancellations or rescheduled appointments, otherwise the full session fee is due**. Once you've completed your final session, or in the event that you have not attended a therapy session in three months, the client/therapist relationship will be considered closed. You may initiate further contact to reestablish the therapeutic relationship at any time.

FEE POLICY: Full Payment or copays (other than insurance portion) are due at the beginning of each session. You may pay by credit card, cash or check. There is a $35 fee for returned checks. Insurance claims will be submitted by me. If I am an out-of-network provider, I will provide receipts that you may submit to your insurance company. I offer a limited number of insurance and sliding scale appointments. Please inquire about openings and rates.

Fees for Services:
Individual sessions (45 to 50 min) = $120.00
Individual sessions (75 min) = $150.00
Marital/family sessions (60 min) = $150.00
Marital/family sessions (75 min) = $180.00
Missed Appointment (w/o 24 hours advance notice): **Full Fee** regardless of insurance rate
Review of Records/Written Reports= $120/hr-billed in 15-min increments
Any Legal Work (includes consulting, depositions, reports, etc.) = 250/hr billed in 15-min increments
Court Appearance (door to door, paid in advance, minimum 4 hrs): $250/hr
Telephone consultation = $30 per 15 minutes
Telephone consultation with attorney = $50 per 15 minutes

Please Initial:
___Weapons of any kind, such as guns, knives, etc., are prohibited in the office, regardless of legal status to carry or conceal.
___No recording of our sessions is allowed.
___I understand that DeeAnn Paul, LPC is acting as my psychotherapist and will not participate in court related activity, custody disputes, or any other legal services. I understand that if I choose to engage DeeAnn Paul in court-related activity that psychotherapy services will be terminated as the therapist-client relationship will have been compromised. I have received clarification as needed.

CONFIDENTIALITY:
The highest standards of confidentiality will be upheld in the therapeutic process. I understand that my therapist respects my right to privacy and that information provided to my therapist will generally be released to others only by my written consent. I understand that my therapist is required by law to disclose confidential information without my consent under certain circumstances that include, but are not limited to, the following:

- If the client is evaluated to be a danger to him/herself or others;
- If any elderly, disabled person or minor child is suspected to be a victim of abuse or if I or my child divulge information about such abuse;
- If a court order or other legal proceeding or statute requires disclosure.
- If my sessions are paid by a third party (such as an insurance company) my therapist may be required to provide this party with documentation of our sessions without my written permission. For out-of-network reimbursement, my therapist will be required to disclose my identifying information and a psychiatric diagnosis. I understand that I am able to ask questions on limits to confidentiality at any time.

I understand that my therapist may occasionally consult with other professionals about a case. Every effort is made to protect the identity of the client. The consultant is also legally bound to keep the information confidential. I understand that unless I object, my therapist will not tell me about these consultations unless she determines it to be beneficial to the therapeutic process.

Minor Clients: Parents have a right to receive feedback on their child's therapy. However, personal information disclosed by a minor will be kept private unless it pertains to the imminent danger of the child or another person. In order to foster a trusting environment for the minor, the therapist must use discretion when disclosing information to parents. We will discuss this in detail in our initial session and throughout the course of therapy, as needed. If applicable, I must receive a copy of the current divorce or custody decree to ensure proper consent, confidentiality and disclosure of information. Exceptions to parental consent may apply to minors 16 years or older who present for treatment regarding sexually transmitted diseases, pregnancy related issues, substance abuse, and/or if the minor is emancipated.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES
If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made, you are entitled to file a complaint with the **US Department of Health and Human Services, 7500 Security Blvd, Baltimore, MD 21244**. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

Full HIPAA policy is available, upon request.

Your signature indicates that you have received and read the Policies, Procedures and Consent to Treatment form and agree to abide by the terms therein:

_____ _____
Signature (Client or Parent/Guardian) and Date Signature

_____ _____/____/_____
Minor Client's Name (if applicable) and DOB