Great Life Counseling Center
14275 Midway Rd., Ste. 260
Addison, TX 75001
Felicia Fisher, Ph.D./413-842-4522/GREATLIFECONSULTS.COM

~ Welcome ~

Please read and complete the forms of this packet. Please note any questions you have and discuss them with your psychologist prior to or during the first session.

Packet Contents:

1. **Demographic/Financial Responsibility and Private Fee Schedule**
2. **Credit Card Authorization Form**
   (*please complete this form, even if you plan to pay by cash or check)*
3. **Office Policies and Consent to Treatment**
4. **Notice of Audio/Video Recording**
5. **Intake Questionnaire**

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DEMOGRAPHIC & INSURANCE INFORMATION

Client Name: _____ DOB: _____/_____/_____ Age: _____

Home Phone: _____-_____-_____ Cell: _____-_____-_____ E-mail: _____@_____

Ethnicity: _____ Religious/Spirituality/Faith Orientation: _____

Relationship Status: ☐ Single ☐ Partnered ☐ Partnered-Cohabitating ☐ Engaged ☐ Married ☐ Other_____

I authorize text messages to my cell phone and messages to the contact numbers & email provided YES NO

Residential Address: _____ City: _____ Zip: _____

Employer: _____ Position/Type of Work: _____

Emergency Contact: _____*Relationship:* _____*Phone:* ____-_____-_____

Referred by: ☐ Insurance Company ☐ Internet Search ☐ Physician ☐ Friend ☐ Other: _____

Insurance information - PLEASE PROVIDE PHOTOCOPY OF INSURANCE CARD

Name of Insured (Policy holder):_____ Date of Birth of Insured: _____/_____/_____

Insurance Carrier: _____ Insurance Phone#: _____ Co-pay $_____

Deductible: _____ Deductible Met: _____ Pays at: _____

Policy/ ID#: _____ Group#: _____ Employer: _____

PRIVATE PAY FEE SCHEDULE

Direct Contact Fees (may be covered/reimbursed by insurance):

Individual Psychotherapy Sessions (55 min)……**$145/hour**
……**Additional psychotherapy session time will be pro-rated by 15-minute increments**
……..**Weekend session surcharge (per 55 minutes) = $15/hour**

Phone & E-Consultation fees (not covered by insurance)……**15 min. or less = FREE;**
……**15+ min. = $145/hour (pro-rated)**

Indirect contact/Administration fees (not covered/reimbursed by insurance)

Career Assessment (Strong Interest Inventory, Confidence Profile, and Myers-Briggs Type Indicator)
……..**$250 + admin/material costs for test administration & written report**

Other services (i.e. write letters, fill out forms, report writing)……**$145/hour (pro-rated)**
Legal (attorney calls, testimony preparation, court appearances, etc.)……**$300/hour (pro-rated)**
……**(4 hour minimum/retainer = $1200)**
Preparation of Record Summary Letters.……**$145/hour (pro-rated)**
Returned/Invalid Check Fee……**$50.00**
Late Cancellation Fees (less than 24 hours of notice)……**50% of session fee**
No show Fees (notice not provided prior to scheduled appointment time)……**100% of session fee**

- If your Great Life clinician has authorized a session rate modification/discount/coupon, please note on line below.

GLCC clinician initial_____

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ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

- Great Life Counseling Center clinicians are currently out-of-network providers for all insurance companies, except Blue Cross Blue Shield PPO. If you would like to pay through BCBS, please contact your representative to verify your behavioral healthcare coverage & inform your psychologist prior to your initial appointment. **Clients are ultimately responsible for the verification of behavioral healthcare benefits with their insurance provider.**
- Great Life Counseling Center will electronically submit claims to BCBS. BCBS will be billed for the contracted service fee minus your copayment or you will pay the full contracted service fee and submitted claims will issue a credit toward your deductible.
  - Walkout statements for out of network claims can be downloaded through your profile with our electronic health records system-TherapyAppointment.com.
  - Great Life Counseling Center may be required to release treatment information about your care to your insurance provider including, but is not limited to, diagnosis codes, dates of service, treatment plans, and treatment progress.
  - Clients are financially responsible for costs incurred when an insurance claim is denied due to changes in, lapses or exhaustion of benefits or termination of coverage for any reason.
- Private payment of services, copays, and administration fees are due at the time of each appointment in the form of **cash, check, or charge**. All checks should be made out to **Great Life Counseling Center.** MasterCard, Visa, American Express, & Discover are accepted. Detailed receipts with CPT codes can be downloaded from your profile on TherapyAppointment.com.
- Clients may be given the option to add no show or late cancellation charges to the cost of the next session, as long as the next session is scheduled to occur within 10 days of the cancellation. Clients are also welcome to mail a check by the 10-day deadline. Please note: no show/late cancellation fees are not usually reimbursed by insurance companies.
- Great Life Counseling Center reserves the right to charge your credit card, email or mail to your address an invoice, and/or utilize a collection agency in efforts to address outstanding balances. You are also responsible for making sure Great Life Counseling Center has updated contact & billing information.

With my signature below, I acknowledge the statements above and accept financial responsibility for services rendered. I also authorize Great Life Counseling Center to bill or charge me directly for services provided, not covered by insurance, or any administration fees not covered by insurance.

Client Signature: _____ Date: _____

A copy of this completed & signed document will be provided at your request

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Credit Card Authorization Form

****It is the policy of this office to keep a debit/credit card on file. You may pay by cash or check, but a card must still be kept on file.****
This policy exists both for your convenience as well as a way to ensure that outstanding balances are paid in a timely manner. You will be notified via phone/voicemail, text, and/or email prior to any charges being applied to your card.

With my signature, I authorize Great Life Counseling Center to charge my credit/debit card & imitate my signature for the e-sign authorization for the following outstanding charges:

- **All visits for which payment was not made at time of visit (this includes fees for service, deductibles, and co-pays).**
- **50% of the session fee for each late cancellation (less than 24 hours of notice)**
- **100% of the session fee for each no show**

_____ _____
Client/Card Holder Signature **Date**

Name _____
Print Last *First* *Middle Initial*

Name on Card (if different)

_____

Type of Card: □ Visa □ MasterCard □ Discover □ American Express

Credit Card Number _____ - _____ - _____ - _____ CVV Number _____ 3-digit number on **back of** card or 4-digit number on **front** of AE card

Expiration Date _____

Card Holder's Billing Address for Credit Card Statements:

_____
Street Address Apt./Ste./Room #

_____
City *State* *Zip*

Card Holder Signature _____, Date ____ /_____ /____

Email address and/or phone number for receipts**_____**

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Office Policies and Informed Consent

Welcome and thank you for entrusting Great Life Counseling Center with your care! This document contains important information about our professional services, business practices, and it will serve as a therapeutic contract. Please read it carefully and jot down any questions you would like to discuss.

THE THERAPY PROCESS

Psychotherapy is treatment process in which the results tend to be gradual and long lasting. Research shows client satisfaction with treatment is highly correlated with the quality of the therapeutic relationship. Great Life Counseling Center aims to provide a comfortable & inviting environment where clients can share their strengths and celebrations as well as work through their challenges sorrows. Psychotherapy treatment will foster collaboration, candor, and accountability as every discussion shares the aim of fostering the healthy development of each client's relationship with their self, family & community. Tools & information gained from the psychologist's years of formal education & professional experience will be shared whenever relevant & appropriate. However, some of the most powerful breakthroughs or revelations often come from the psychologist's facilitation of the client's self-discovery. This self-discovery includes, but is not limited to, increased awareness & development of personal strengths & resilience due to a healthier perspective, sense of direction, and greater resolve.

Although therapy has many potential benefits, there are some inherent risks or challenges. Therapy often requires clients to be vulnerable with their psychologist as they recall unpleasant events and discuss troubling or embarrassing issues. Consequently, people sometimes experience some feelings of discomfort or distress in reaction to issues discussed during sessions. However, therapy has been shown to have benefits for those who undertake it with a competent & genuine clinician. Although there are no guarantees about the outcomes of therapy, individuals often report significant reductions in feelings of distress, a greater sense of resolution or peace about losses experienced, improved relationships and self-esteem, more effective coping and resource utilization, and a greater outlook on life.

Similar to any other relationship, therapy is most effective when the interpersonal chemistry, collaboration and candor between the client and psychologist are healthy and evident during each interaction. It is important clients understand that achieving the benefits of therapy requires much effort on their part, including consistent attendance & active involvement, honesty (with client's self & psychologist or therapist), and follow-through (on recommendations & agreements). The psychologist's role is to listen, assess, and intervene with questions/suggestions/recommendations that will strengthen your personal reflections, problem solving skills, coping skills, and overall perception of life's challenges. Clients are encouraged to make efforts to be self-reflective, forthright & honest with psychologist, and open to considering new perspectives & behaviors.

TERMINATION OF THERAPY PROCESS

Ideally, the therapy sessions will end when psychologist & client agree treatment goals have been adequately met. However, there are times when therapy sessions need to be discontinued for a time or spaced out due to financial reasons, conflicts in schedule, or physical illness. The psychologist may also decide that client would be better served by another clinician and refer client to a colleague or reputable agency.

Regardless of reasons for termination, continuity of care is vital to effective treatment and clarity regarding the status of the therapeutic relationship is a necessity for accurate record keeping. Thus, it is preferred that clients inform their psychologist of their intention to terminate sessions at least one session in advance. When this is not feasible, clients are asked to inform their psychologist of their plans to discontinue or take

a break from sessions as soon possible. Unless a date & time has been established for the next session, termination of the therapy relationship will be assumed after 2 weeks of no correspondence or booking of the next appointment. Former clients are asked to settle any outstanding balances within 2 weeks of their last appointment. Clients who have terminated therapy are always welcome to return to treatment at any time as long as outstanding balances have been resolved. Great Life Counseling Center and its associates reserve the right to charge client via the provided credit card, email or mail client an invoice, or utilize a collection agency in efforts to address outstanding balances.

OUTSIDE-OF-SESSION COMMUNICATION & EMERGENCY PROCEDURES/POLICIES:

- Telephone, text, & email consultations between office visits are welcome. However, any contact outside of session will be kept brief. Clients are encouraged to consider scheduling additional sessions or waiting until their next session to discuss matters that will take more than 15 minutes to explore. If out-of-session correspondence requires more than 15 minutes of the psychologist's time, charges for each 15 minute increment will incur (including the first 15 minutes). Payment for such consultations is due at the start of the next session or within 10 business days (whichever occurs first).

- **Clients are welcome to transmit voicemail, email, or text messages to their psychologist/clinician but these communications must remain brief (i.e., not requiring more than 15 minutes of therapist's time to review & respond) or charges will incur**. On weekends and holidays, messages are checked less frequently. Calls, texts, & emails will generally be responded to within 24 hours or by the end of the next business day.

- **Please note: Great Life Counseling Center's contact numbers are *not* emergency numbers. In the event of a mental health or medical crisis, please call 911 or one of the following crisis lines, which are available 24/7:**
  - Suicide & Crisis Center of North Dallas – **214-828-1000**
  - National Suicide Prevention Lifeline – **1-800-273-TALK**
  - National Domestic Violence Hotline – **1-800-799-SAFE**
  - National Sexual Assault Hotline – **1-800-656-HOPE**
  - If your crisis is due to a medical issue or medication, contact your physician or psychiatrist.

- Vacation: Clients are informed in advance whenever their psychologist plans to be unavailable for more than 48 hours. In these events, arrangements may be made for coverage, if the psychologist determines its necessary or it is requested by client. Otherwise, clients who experience pressing concerns while their therapist is unavailable are encouraged to utilize one of the crisis lines listed above.

CONFIDENTIALITY:

In most cases (see "Exceptions to Confidentiality" below) communications between client and psychologist will be held in strict confidence - unless client provides psychologist with written permission to release information about treatment or there is an imminent safety threat.

Protecting client privacy is a high priority for Great Life Counseling Center & its associates. Intake paperwork, therapy notes, consultation notes, & reports are kept in a locked file cabinet until they are typed or scanned & uploaded into an accredited web-based electronic health records system, which is currently TherapyAppointment.com. Scheduling & file information on TherapyAppointment.com is protected with bank-level security, which includes the highest levels of data infrastructure, virus prevention, spam filtering, and encryption measures. Prior to being archived on TherapyAppointment.com, encrypted records are kept on a secured flash drive so they are not saved on any computer. For additional information about your privacy rights & HIPPA, visit the HIPPA website:

http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

EXCEPTIONS TO CONFIDENTIALITY

Safety Concerns

Psychologists & other mental health professionals are legally-mandated to report all known or suspected instances of child abuse, dependent adult abuse and elder abuse. Psychologists are may also break client confidentiality in an attempt to prevent a client from harming themselves or others.

Professional Consultation

In accordance with recommended best practices, Great Life Counseling Center clinicians regularly consult with each other and enjoy collaborating to provide the best care possible. These consultations may include the review of video recordings or just an exploration of different strategies for improving the likelihood of positive outcomes. However, identifying information is never shared with anyone outside of the clinical team and, after recordings or presentation materials have been reviewed by the Great Life Counseling Center team, they are immediately shredded or deleted.

Electronic Communication, Videoconferencing, or Phone

Great Life Counseling Center is nearly paperless business and relies on different information technologies such as emails, text messages, phone calls, video conferences, fax, & an electronic medical record system to communicate, record, and store client information as well as transmit business transactions. Use of these technologies allows Great Life Counseling Center to serve your needs more efficiently and effectively and Great Life Counseling Center associates take reasonable steps to protect the privacy of its clients & minimize risk of any breach or errors in transmission. However, clients are required to acknowledge and accept the inherent risks of such technologies and electronic mechanisms (e.g., risk of information being erased or destroyed due to a malfunction or act of God; information intercepted and/or hacked by unauthorized parties; or information being erroneously transmitted to the wrong email, fax number, or phone number).

CLIENT ACKNOWLEDGEMENT OF POLICIES AND CONSENT TO TREATMENT:

- With my signature below, I acknowledge that I have had ample opportunity to review Great Life Counseling Center's policies.
- My signature indicates that I understand & accept the stated policies, the expectations for full participation in the treatment process, and the risks noted herein.
- Finally, my signature indicates my willingness to abide by the terms of this agreement.

Client Signature: _____ Date: _____

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Notice of Audio/Video Recording

Great Life Counseling Center is able to assure the highest quality services to each client due to an emphasis on qualitative reviews, training, and clinical collaboration. In order to ensure the highest standard of care and safety, Great Life Counseling Center audio/video records office activity for surveillance purposes and your Great Life Counseling Center clinician may audio/video record clinical meetings for research/training purposes. Recordings of clinical meetings may be qualitatively reviewed during supervision/consultation meetings and group case consultation meetings with members of the Great Life Counseling Center clinical team. The limits of confidentiality delineated in the Consent for Counseling Treatment form apply to supervision/consultation meetings and group consultations with members of the Great Life Counseling Center clinical team.

This form will become part of your clinical record and a hard copy will be provided to you upon request. If you have any questions about this form, you are welcome to consult your Great Life Counseling Center clinician for clarification. Your signature below indicates you give Great Life Counseling Center and your clinician permission to audio/video record and you understand the following:

1. **The purpose of audio/video recordings shall be for training/research and surveillance of office premises. Your Great Life clinician may utilize samples of or complete audio/video recordings for qualitative reviews and constructive feedback from members of the Great Life Counseling Center clinical team.**
2. **The content of these recordings will be kept in strict confidence through encryption and a secure storage system. Furthermore, they will be deleted after they have served their purpose or 4 weeks has passed since the recording. Recordings of clinical meetings will be stored separately from the clinical record and will not be transmitted to or shared with any external entities or persons prior to deletion.**
3. **The use of personal recording devices (e.g., phones) to record all or parts of clinical sessions without the expressed consent of the Great Life Counseling Center clinician is strictly prohibited.**
4. **You may request in writing the suspension or termination of audio/video recordings of clinical meetings at any time by requesting to sign the terminate/suspend session recordings form. Office surveillance of common areas like the waiting room and hallways cannot be terminated or suspended for security reasons but will be kept confidential until deleted.**

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INTAKE QUESTIONNAIRE

NAME: _____

PRIMARY COMPLAINTS: What brought you into therapy today? _____
_____
_____
_____
_____

EXPECTATIONS: What do you wish to change or accomplish as a result of therapy?
_____
_____
_____

HISTORY OF TREATMENT: Have you been in therapy before? ☐ Yes ☐ No If yes, please note the when, name of clinician/agency, and primary issues addressed:
_____
_____
_____

Reflecting on the last 6 months, please circle all that apply:

Frequently sad or depressed	Feeling restless or keyed up
Overwhelming worries	Restless unsatisfying sleep
Difficulty falling asleep or staying asleep	Muscle tension
Unable to concentrate	Mood Swings
Irritable and/or short temper	Decreased need for sleep (only need 3-4 hrs)
Significant change in weight	Feel more talkative than usual
Low energy level/fatigue	Excessive spending/shopping
Feeling excessive guilt or shame	Excessive gambling
Unable to relax	Easily distracted by unimportant things
Lack of appetite/increased appetite	Take too many risks
Loss of interest in activities/hobbies	Troubling thoughts about the past
Feeling hopeless	Nightmares
Feeling worthless	Exaggerated startle response
Difficulty motivating	Too neat and orderly
Withdrawn/isolating self	Repeating certain behaviors over and over
Cry easily/often	Easily upset or angered
Difficulty making a decision	Feeling different from most people
Difficulty finishing tasks	Shy around others
Thoughts to hurt self	Increasingly forgetful
Attempts to harm yourself	Strong fears
Thoughts to hurt others	Difficulty with work or school
Threats to hurt others	Use of painkillers and analgesics
Feeling ill/sick	Stomach aches/vomiting

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Medical History

Are you currently being treated for any medical problems? □ Yes □ No
Are you currently taking any medications? □ Yes □ No
List medications:

Dosage	Type	For (i.e. depression)	Prescribed by

Are you currently taking over the counter medications, herbs or supplements? □Yes□ No
Are you presently in good health? □Yes □ No
Do you engage in physical activity? □Yes □ No
If yes, what activity? _____ How often?_____

Do you smoke cigarettes (cigars, chew)? □ Yes □ No #_____per day
How much alcohol do you drink? #_____per day _____# per week
Do you drink caffeinated beverages? □ Yes □ No If yes, how many per day?_____
Do you use illicit drugs? □ Yes □ No
If yes, how often and what drugs do you use?_____
Have you ever tried to cut down or stop using alcohol or drugs? □ Yes □ No
Has anyone ever asked you to cut down on your drinking? □ Yes □ No
Have you ever been hospitalized for any emotional/ mental health condition? □Yes□ No

Have you experienced or witnessed a traumatic event? (*parental violence, domestic violence, community violence, natural disaster, injury or death to a loved one*, etc) □ Yes □ No
Do you have a history of domestic violence? □ Yes □ No
Do you have a history of verbal, emotional or physical abuse? □ Yes □ No
Do you have a history of sexual abuse or sexual assault? □ Yes □ No
If you answered 'Yes' to any of the questions in this box, please provide the general details below (including date/duration of events)

_____
_____

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SUPPORT SYSTEMS

Do you have one or two friends that you consider close and feel you can depend on?	☐ Yes ☐ No	
Do have a religion or spiritual practice that you experience as supportive?	☐ Yes ☐ No	
Do you belong to any social groups or participate in hobbies with people that you enjoy?	☐ Yes ☐ No	
Is there a family member that you trust and can go to in times of emotional need?	☐ Yes ☐ No	
Are there other people or aspects of your life that you consider supportive?	☐ Yes ☐ No	

FAMILY HISTORY

Have <u>you</u> or <u>anyone in your family</u>, experienced any of the following? If yes, please note their relationship to you. Please include extended family such as grandparents, uncles/aunts, siblings, and so on.

Has anyone experienced:	**Family Member(s)**
Anxiety	
Depression	
Bipolar disorder	
Learning disorders (ADHD, dyslexia, etc).	
Illicit drug use	
Alcohol abuse	
Schizophrenia	
Anger	
Eating Disorder	
Phobias	
Hospitalization for Mental Health Condition	
Attempted or completed suicide	

Please note any other areas/issues of concern:

_____
_____
_____
_____

~ Thank you ~