Great Life Counseling Center
14275 Midway Rd., Ste. 260
Addison, TX 75001
Jantel Jordan, Psy.D./413-798-4522/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.

Adult Assessment Packet Contents:

1. **Demographic/Financial Responsibility Form**
2. **Private Fee Schedule Form**
3. **Credit Card Authorization Form**

(*please complete this form, even if you plan to pay by cash or check)*

4. **Office Policies and Consent to Treatment Form**
5. **Supervision/Consultation Disclosure Form**
6. **Notice of Audio/Video Recording**
7. **Intake Questionnaire**

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DEMOGRAPHIC/FINANCIAL RESPONSIBILITY FORM

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

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

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

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: _____

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.
- ➢ Great Life Counseling Center will electronically submit claims to BCBS. BCBS will be billed for the contracted service fee minus your copayment or your full payment of the contracted service fee will be credited toward your deductible. 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.
- ➢ Private payment of services, copays, and administration fees are due at the time of each appointment. Walkout statements for out of network claims can be downloaded through your profile with our electronic health records system-TherapyAppointment.com.
- ❖ If your insurance company should deny payment or reimbursement, you remain ultimately responsible for any outstanding financial debt associated with services provided, including no show/late cancellation fees (which are not covered by insurance). Great Life Counseling Center reserves the right to charge your credit card on file or other credit cards used for prior payments, email or mail client 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.

Please Acknowledge the Above Statements with Your Initials _____

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FEES & PAYMENT:

- Payment is due at the time services are rendered 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 can be downloaded from your profile on TherapyAppointment.com.
- ❖ For insurance reimbursements or more detailed receipts, clients may request a walkout statement to be given in paper form or sent to an email address.
- ❖ Clients will 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 but are advised to mail it at least 4 days prior to the 10 day deadline. Please note: no show/late cancellation fees are not usually reimbursed by insurance companies.

PRIVATE PAY FEE SCHEDULE

Direct Contact Fees (may be covered by insurance):

Short Psych. Evaluation (Clinical Interview and up to 2 measures)
……**$750 for test administration & written report**

Full Psych. Evaluation (Clinical Interview and up to 4 additional measures)
……**$1500 for test administrations & written report**
……**Up to $250 per additional measure**

Consultation with Other Professionals (with written consent)……**more than 15 min. - $130/hour (pro-rated)**
(i.e., teachers, school psychologist, psychiatrist, doctor, etc.)

Indirect contact/Administration fees (not covered by insurance)

Other services (i.e. write letters, fill out forms, report writing)……**$130/hour (pro-rated)**
Legal (i.e., attorney calls, reports, testimony preparation & court appearances)……**$300/hour (pro-rated)**
……**(4 hour minimum/retainer = $1200)**
Preparation of Record Summary Letters.……**$130/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 a Great Life clinician has authorized a session rate modification/discount/coupon, please note on line below & confirm agreement during initial appointment.

GLCC clinician initial_____

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

_____Date_____
Client/Guardian signature

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 insure 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

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For Adult Assessment

OFFICE POLICIES AND INFORMED CONSENT

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

THE ASSESSMENT PROCESS

Assessment includes a clinical interview, review of records, testing, and a feedback session. The testing process involves the administration of measures that examine areas such as intellectual functioning, academic aptitude, memory, attention, and emotional functioning. Great Life Counseling Center clinicians will choose measures that are best suited to address a client's presenting questions and concerns. As a result, the length of testing is variable, and testing may be spread over several testing sessions to ensure optimal testing conditions. During the feedback session, clients will have the opportunity to review test results with the clinician and to ask any questions they may have. In addition to verbal feedback, clients receive a written report consisting of background information, test results, and recommendations. The assessment report is typically provided to clients within two to three weeks after testing has been completed, assuming that there are no 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 and their legal guardians 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.
- **Great Life Counseling Center's contact number is *not* an emergency number. 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: Active clients are informed in advance whenever their psychologist plans to be unavailable for more than 2 business days. In these events, arrangements may be made for coverage, if the psychologist determines it is necessary or it is requested by the client. Otherwise, clients are encouraged to utilize one of the crisis lines listed above for assistance in the absence of their GLCC clinician.

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).

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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.

_____Date_____

Client/Guardian signature

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Supervisory/Consultation Disclosure Form

Jantel Jordan, Psy.D. is a Postdoctoral Fellow at Great Life Counseling Center. In order to become a Postdoctoral Fellow for Great Life Counseling Center, Dr. Jordan had to achieve her doctorate in the field of psychology along with at least 3 years of experience practicing at other clinical sites. Dr. Jordan is now eligible for provisional licensure in the state of Texas and she has begun the application process. She has been authorized by the Texas State Board of Examiners of Psychologists to practice as a trainee under the guidance of a Texas licensed psychologist in good standing.

In order to ensure the highest standard of care, Dr. Jordan and her primary supervisor will meet weekly to discuss and review Dr. Jordan's documented work with you. The limits of confidentiality delineated in the Consent for Counseling Treatment form apply to supervision and case consultations with members of the Great Life Counseling Center clinical team. 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.

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 Dr. Jordan or one of her supervisors for clarification. Signing this form acknowledges your informed consent for treatment by a clinician under supervision, including your permission for your clinician to disclose your confidential information with her supervisor and consult with other members of the Great Life Counseling Center clinical team. You will have the right to withdraw permissions for consultation disclosure at any time but it will result in the transfer of your clinical work to a licensed psychologist.

Therapist's Name: Jantel Jordan, Ph.D.
Primary Supervisor's Name: Nikki Stillo, Ph.D.
Secondary Supervisors' Names: Kevin Lambert, Psy.D. and Blair Kenney, Psy.D.

_____Date_____
Client/Guardian signature

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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 can not be terminated or suspended for security reasons but will be kept confidential until deleted.**

_____Date_____

Client/Guardian signature

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INTAKE QUESTIONNAIRE

NAME: _____

PRIMARY COMPLAINTS: What issues or concerns led to your decision to pursue an assessment today?

_____
_____
_____

EXPECTATIONS: What do you hope to change or accomplish as a result of this assessment?

_____
_____
_____

HISTORY OF TREATMENT: Have you had a psychological assessment 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 ~