~ 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. **Office Policies and Consent to Treatment**
2. **Intake Questionnaire**

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 many 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 & candor between the client and psychologist are healthy & 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 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.

- **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: Clients are informed in advance whenever their psychologist plans to be unavailable for more than 24 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. In the case of couples or family therapy, the psychologist will not disclose confidential information about treatment to a third party unless all adult participants or legal guardians provide written authorization to release such information.

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 in a locked room until they are typed or uploaded onto an accredited web-based electronic health records system, which currently is 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, 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 also may break client confidentiality as they attempt to prevent clients from harming themselves or others.

Professional Consultation

In accordance with recommended best practices, your psychologist may consult with other professionals regarding better ways to help you reach your treatment goals. However, client names & other identifying information are never shared and remain protected.

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_____

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

Great Life Counseling Center
14673 Midway Rd., Ste. 213 or 230
Addison, TX 75001
GREATLIFECONSULTS.COM

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

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)

_____
_____

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 ~