(Please Print)

Date _____/_____/_____

Client Name ____GenderID______Date of Birth ___/___/____

Address ____ City/State ________________ Zip_________

Social Sec. # (last four only)________ Email Address: ____

Home ( ) __________________ Work ( ) __________________ Cell ( )________________

Place of Employment:____

How did you hear about us?_____________________ May we contact your referral source? YES or NO? (circle one)

Circle One: Minor Single Married Partnered Divorced Separated Widow Living Together

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IF CLIENT IS A MINOR Legal Guardian's name ______________________________

Address ______________________ City ______________________ State __________ Zip __________

Home ( ) ______________________ Work ( ) ______________________ Cell ( ) ______________________

Per Texas Family Law, Custodial Parents must provide the most recent custodial agreement to protect the legal rights of the child. If you need to provide this document please bring a copy to your child's first session. Children will not be seen without this document in the file. Please initial if you are required to provide proof of custody. (_____) initial

HOUSEHOLD INFORMATION (List all who live in the home)

Name	Role (Husband, wife, child, partner, etc.)	Date of Birth
		_____/_____/_____
		_____/_____/_____
		_____/_____/_____
		_____/_____/_____
		_____/_____/_____

INSURANCE & FINANCIAL INFORMATION

Insurance Company_________________________________Phone (on back of card)____________________________

Primary Insured's Name____________________________*Their* Social Security #______________________________

Relationship to Client ______________________________I.D. Number____

Parent Date of Birth_____/______/_______ Group #____

Street Address (if different from Client)____

City___________________________________State_________Zip Code__________________

Home Phone___________________________Work Phone________________Cell Phone_______________________

Employer_____________________________Occupation_________________________ Years with Employer _____

Employer's Address____

City____State_________ Zip Code____________

*SECONDARY Insurance Company*________________________*Phone (on back of card)*______________________

*Secondary Insured's Name*_______________________________*Their Social Security#*________________________

*Relationship to Client*_____________________________*I.D. Number*____

*Date of Birth*_____/______/_______ *Group #*____

EMERGENCY CONTACT INFORMATION

In the event of an emergency, please contact: Name ____

Address ____ Relationship ___________________________

Home/Work __________________________________ Cell ______________________________________

PRESENTING PROBLEM(S)

Please describe your reasons for seeking counseling (include month/year the problem started):

____

When did you last experience suicidal thoughts or thoughts of harming self or others? Have you ever attempted suicide?

____

Was there an event which made these issues or problems begin? Yes _____ No _____
If yes, please describe: ____
____

Please indicate the severity in which your current problems are affecting the following areas:

	No Effect	Little Effect	Some effect	Much effect	Significant effect
Marriage/Relationships	1	2	3	4	5
Family	1	2	3	4	5
School/Job Performance	1	2	3	4	5
Friendships	1	2	3	4	5
Hobbies	1	2	3	4	5
Financial Situations	1	2	3	4	5
Physical Health	1	2	3	4	5
Anxiety level/Nerves	1	2	3	4	5
Mood	1	2	3	4	5
Eating Habits	1	2	3	4	5
Sleeping Habits	1	2	3	4	5
Sexual Functioning	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Ability to Control Temper	1	2	3	4	5
Spirituality	1	2	3	4	5

SUBSTANCE USE HISTORY

Have you ever used illegal drugs?Yes /No ___ What kind? _________ When? _____ How much/How often? __________
Did you ever abuse alcohol? Yes /No ___ What kind? _________ When? _____ How much/How often? __________
Do you drink coffee? Yes /No ___ How much? _______ How often? __________
Do you smoke cigarettes? Yes /No ___ How many? _______ How often? __________
Do you drink alcohol? Yes /No ___ What kind/How much? __________ How often? __________

FIREARMS: Do you have firearms in your household? Y/N Are they unloaded and safely locked away? Y/N

MEDICAL HISTORY

Please list any prescription medication you currently use: (Name, dosage, frequency) Psychiatric medication also.

____

____

Please list any over-the-counter medications you currently use: (Name, dosage, frequency)

____

Describe any major illnesses or accidents you've experienced throughout your life:

____

____

Describe any medical or psychiatric conditions of your parents and/or siblings:

____

PSYCHIATRIC HISTORY

SJCardwell Counseling & Consulting PLLC has CONSENT to contact my physician/psychiatrist : Yes _____ No _____
Signature of Patient or Guardian: ____ Date:____________________
Relationship of Guardian to Patient: ____________________________
Who is your primary care physician: ________________________________
Who is your psychiatric medication prescriber: ________________________
Do you have any allergies? Yes _____ No _____ Please describe any known allergies:___________________________
Have you ever received psychiatric or counseling before: Yes _____ No _____When?________
What type of care did you receive? Inpatient _____ Outpatient _____ Both _____
Are you currently seeing another Counselor? Yes _____ No ______
Did your doctor prescribe medication? Yes _____ No _____ Prescription/Dosage _______________________

MILITARY HISTORY

Have you ever been a member of the armed forces? Yes____No____ Which Branch? ______________________
Have you been active in combat? Which? _____________________
Were you injured physically or psychiatrically? Yes _____ No _____
Where did you receive treatment? __________________________

FEE POLICY

Our office cannot verify your coverage but may be aware of your company's insurance deductible and co-payment. We will file your insurance claims unless you tell us otherwise. **We request that you confirm your benefits with your insurance company to accurately identify your financial responsibility for sessions.** Your insurance policy is a contract between you and the insurance company. Therefore, you, as the insured, are responsible for payment of amounts refused or determined unnecessary by your insurance company. All insurance benefits will be assigned to Susan J Cardwell, MA, LPC. This assignment will remain in effect until revoked by client in writing. Although it is possible that your mental health coverage deductible may have been met elsewhere, this amount will be collected until the deductible payment is verified by the insurance company.

Clients are responsible for payment at the time of services. Court Testimony Fees are to be paid in advance with refunds provided if necessary. Cash, personal checks, MasterCard, Visa, and Venmo accepted.

OFFICE FEES

Insurance Code	Description	Time	Fee
90791	Intake	60 min	$165
90834	Individual Therapy	45-50 min	$135
90847	Couple/Family Therapy	45-50 min	$155
90837	Individual Therapy	60 min	$155
Not Billable to Insurance	Late Cancelation/No show	n/a	$100
Not Billable to Insurance	Returned Check (NSF)	n/a	$45
Not Billable to Insurance	Consultation Services	60 min	$150
Not Billable to Insurance	Fees, Letters, & Reports	15 min	$45+
Not Billable to Insurance	Court Testimony, Preparation	30 min	$150 Paid in Advance

I understand that I am financially responsible to Susan J Cardwell, MA, LPC for the charges incurred by me and/or my dependents. My signature below acknowledges my total responsibility in paying for any fees not covered by my insurance company at the time of service.

Signed:____Date:_________________________

Credit Card Authorization

I authorize Susan J Cardwell, MA, LPC to keep my signature on file and to charge my Visa/MasterCard account for recurring charges of ($_100.00_) for missed appointment or less than 24 hour cancellation notice.

I understand this authorization is valid for one year unless I cancel the authorization in writing. I promise not to dispute charges (charge back) for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize Susan J Cardwell, MA, LPC to disclose information about my attendance/cancellation to my credit card issuer if I dispute a charge.

Cardholder Signature: ____

Client Name: ______________________________Cardholder Name: __________________________

Please Print Please Print

Cardholder Billing Address: ____

City: ____State:_________Zip:_____________

Account #:_______________________________________CVV: _____ Expiration Date: ________________

Cancellation Policy

It is our policy to charge $100.00 for missed appointments or appointments not cancelled at least 24 hours in advance. If the office is closed, you may email, text, or leave a voicemail.. Time has been reserved exclusively for you, and your courtesy to notify of cancellations allows us to offer that time to someone else. (_______) initial

☞If a client misses two consecutive scheduled sessions without a legitimate reason, the client will be considered to have given a notice of termination of therapy. (______) initial

☞Crisis calls over fifteen (15) minutes will be considered a telehealth session and will be charged accordingly. (_____) initial

Consent for Telehealth

Most Telehealth formats are not HIPAA compliant; Doxy.me/cardwellcounseling is the website that Susan Cardwell uses for Telehealth except when an insurance company requires otherwise. Clients have other format preferences. Please initial to accept responsibility for privacy in your environment during Telehealth. (______)

Release of Information Authorization to Third Party (Insurance Company through billing system)

I authorize Susan J Cardwell, MA, LPC to disclose case records, such as diagnosis, summaries, and other requested information, to the insurance company for the purpose of receiving payment directly to our office. I understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. (_______) initial

Authorization for Care of Records
In the event of the incapacitation or death of my counselor, I authorize the person my counselor has designated to handle my files/records to contact me and assist me in continuity of care, payment, and/or resolution files/records. (_______) initial

Acknowledgement of Review of Notice of Privacy Practices
I have been given the opportunity to review the Notice of Privacy Practices, (HIPAA), which explains how my personal health information will be used and disclosed. (_______) initial

Confidentiality
Our office protects the confidentiality of counseling sessions. A signed "Release for Information" form is required in order to release any information about a client. All information between counselor and client is considered confidential unless:

- The client presents a physical danger to self or others.
- The probability of client suicide.
- Child/Elder/Disabled person abuse or neglect is suspected.
- A judge signed court order has been issued, a subpoena.
- The client is a non-emancipated minor – in which case the parents or guardians have the right to access the client's records.

In the first three cases, the counselor is required by law to inform potential victims and legal authorities so that protective measures can be taken. (_______) initial

Consent for Treatment
I certify that I have read this agreement and understand the office policies. I give my consent for Susan J Cardwell, MA, LPC to provide me, or my minor child, with counseling services. Individual and couples sessions are up to 55 minutes but could be as short as 30 minutes depending on your Agenda. The process of change begins by clearly defining your goals, learning how thoughts impact feelings, and what behaviors you use to help you cope. We collaborate to develop new skills and healthy attitudes about yourself and others. As a Certified Cognitive Behavior Therapist most work will be CBT which is also considered a client centered approach. Referrals for medication evaluation or for psychological testing may be made to assist in providing the best treatment available. It is your right to know your Diagnosis and Treatment Plan generated through collaboration with the information you provide during your Intake Session. (_______) initial

Professional Relationship
In accordance with Texas Behavioral Health Executive Council and Texas State Board of Examiners of Professional Counselors Code of Ethics in order for counseling to be as successful as possible the professional relationship with the therapist is required by law to be free of **business, personal, social media, or other outside relationships between the therapist and client.** It is vital to remember that therapeutic services can sometimes generate emotions such as anxiety, depression, happiness, and feeling uncomfortable. Counseling may alter your view of an important relationship, and you may change your attitudes toward important people in your life. Such outcomes are possible when people are in counseling, and these changes can be processed during sessions. Social media or social texting with the counselor is not part of counseling. **The professional boundaries with your counselor must be maintained to insure their professional perspective and your emotional safety.**

____
Client Name (Please Print)

____ ____________________
Signature of Client or Personal Representative Date

____ ____________________
Signature of Counselor Date

TX Behavioral Health Executive Council investigates & prosecutes professional misconduct committed by LPCs. Although not every complaint against or dispute with a licensee involves professional misconduct, the Council will provide info: call 1-800-821-3205.

Updated 03/24