Person to Contact in Case of Emergency

Name_____ Relationship_____

Best Contact Number_____Alt. Number _____

Who Can Pick Up Client (if Minor)_____

Office Use Only
Intake Date _____
Reason for referral _____
_____
Counselor _____

THE COUNSELING PLACE
YOUTH INTAKE FORM

Yearly Family Income:_____

Full Name of Client _____

Date of Birth _____ Age _____ Sex _____ Race _____ Religion _____

Address _____

City_____ State/Zip _____ Grade _____ School _____

Custody Paperwork? ☐ Yes ☐ No ☐ N/A Custody Arrangement _____

Caregiver 1 Name _____ Relationship_____ Legal-Guardian? ☐ Yes ☐ No

Address_____ Best Contact Number_____

Email Address_____ Employer _____

Work Phone _____ Drivers License No. _____

Step-parent Name 1 _____ Contact Number _____

Caregiver 2 Name _____ Relationship _____Legal Guardian? ☐ Yes ☐ No

Address _____ Best Contact Number_____

Email Address_____ Employer _____

Work Phone _____ Drivers License No. _____

Step-parent Name 2_____ Contact Number _____

Names and Ages of client's siblings

_____

Client's **Medical** Physician _____ Telephone Number _____

Current Medications _____

Previous Medications_____

Were there any problems during the pregnancy, labor, or birth of the client?_____

Any Problems with: ☐ Vision ☐ Hearing ☐ Speech ☐ Learning ☐ Eating ☐ Sleeping ☐ Health

☐ Seizures ☐ Bathroom Accidents ☐ Arrests ☐ Substance Abuse ☐ Surgery ☐ Hospitalizations

Please specify

_____

Client's usual mood _____ Any history of self-harm? _____ When? _____

Any history of suicide attempts?_____ When _____

Has client been hospitalized for psychiatric care? If yes, explain.

_____

Any previous counseling? ☐ Yes ☐ No Previous Counselor _____

Dates of Therapy? From_____ To_____ For what reason? _____

Have there been any important changes or events in the family, such as deaths, moves, separations, arrests, serious illnesses, that may have affected the client? _____

How does the client get along with other family members? _____

Has the client experienced or been the victim of physical, sexual abuse or neglect? ☐ Yes ☐ No

Please explain _____

Check the behaviors and symptoms that occur to you more often than you like them to take place:

☐ aggressions	☐ fatigue	☐ sexual difficulties
☐ alcohol dependence	☐ hallucinations	☐ sick often
☐ anger	☐ heart palpitations	☐ sleeping problems
☐ antisocial behavior	☐ high blood pressure	☐ speech problems
☐ anxiety	☐ hopelessness	☐ suicidal thoughts
☐ avoiding people	☐ impulsivity	☐ thoughts disorganized
☐ chest pain	☐ irritability	☐ trembling
☐ cutting	☐ irrational thoughts	☐ violent outbursts
☐ depression	☐ judgment errors	☐ withdrawing
☐ disorientation	☐ loneliness	☐ worrying
☐ distractibility	☐ memory impairment	☐ other (specify)
☐ dizziness	☐ mood shifts	_____
☐ drug dependence	☐ panic attacks	_____
☐ eating issues	☐ phobias/fears	_____
☐ elevated mood	☐ recurring thoughts	_____

Please list, in order of importance, the problems for which you are seeking counseling at this time:

_____

If parents are divorced, how did the client adjust? _____

Who primarily disciplines the client? _____ Client's response to discipline _____

Discipline techniques used_____

Discipline that is most effective _____ Least effective _____

How does the client like school? _____

Current grades in school _____ Repeated a grade? ☐ Yes ☐ No Any problems in school? ☐ Yes ☐ No

Please describe problems_____

How does client get along with other children? _____

How many close friends does the client have? _____ Are they older, younger, or same age?_____

Organizations, teams, clubs client belongs to _____

Jobs or chores client is responsible for _____

Hobbies, activities client enjoys _____

What activities does the family enjoy doing together?_____

THE COUNSELING PLACE
Counseling Agreement

Counseling Relationship: The counseling relationship is a professional relationship, not a social one. Sessions may be weekly or at intervals necessary to meet the collaborative treatment goals we have agreed upon. Contact will be limited to counseling sessions that you arrange at a predetermined time convenient for both of us. In case of emergency, contact The Counseling Place by phone (469-283-0242), or another contact number provided by your therapist.

Records and Confidentiality: All of our communication becomes part of a clinical record which is the property of The Counseling Place. Adult files are disposed of seven years after the date of termination of services. Records of minors are disposed of five years after the minor's eighteenth birthday or seven years after the date of termination of services, whichever is longer. Communication between us is confidential except in the following instances:

- I determine you are a danger to yourself or others
- You disclose abuse, neglect, or exploitation of a child, elder, or disabled person
- I am court ordered through a subpoena to disclose information regarding your case
- You disclose sexual contact with another mental health professional
- You direct me in writing to release your records
- I am otherwise required by law to disclose such information

I may use your case records for the purpose of supervision and professional development with other counseling staff members at The Counseling Place. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

Outcome of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing or not continuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to changes in your life, perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these changes can be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Client Rights: Some clients need only a few sessions of counseling; others need several weeks or months. You may end our counseling relationship at any time, although I do ask that you do so in a final session with me. Counseling is a cooperative process between a client and therapist; please discuss any concerns you have openly with me so they can be addressed.

Surveys: Some of our grants that provide funding for services ask that we have those receiving services from the grant complete a survey during various times throughout treatment. We will protect confidentiality with surveys unless otherwise noted by you, the client, in written form.

Complaints: I assure you that my services will be rendered in a professional manner with accepted legal and ethical standards. If at any time you are dissatisfied with my services, please let me know. If I am unable to resolve your concerns, please contact The Counseling Place Executive Director, Deborah Dobbs, at 469-283-0344 or the Texas Behavioral Health Executive Council.

Notice to Clients: The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint. Please call 1-800-821-3205 for more information.

Texas Behavioral Health Executive Council
333 Guadalupe St., Ste. 3-900
Austin, Texas 78701
Tel. (512) 305-7700
1-800-821-3205 24-hour, toll-free complaint system

The Counseling Place
Counseling Fee Agreement

The Counseling Place fee for a 50-minute individual, family or marital counseling session is determined by the client's ability to pay. The fee scale is based on a sliding scale determined by annual gross family income.*

Income	Fee per session	Income	Fee per session
$10,000 and under	$35	$50,000 – 59,999	$60
$10,000 – 19,999	$35	$60,000 – 69,999	$70
$20,000 – 29,999	$35	$70,000 – 79,999	$80
$30,000 – 39,999	$40	$80,000 – 89,999	$90
$40,000 – 49,000	$45	$90,000—99,999	$95
		$100,000 and up	$100

Payment: Payment for the counseling session is **due at the time of the appointment,** unless prior arrangements have been made. Cash, credit/debit card or personal checks made out to "The Counseling Place" are acceptable for payment. **A returned check fee of $25.00 will be charged on any returned check.** If you have an outstanding balance, you may be mailed a statement requesting payment from the agency. Any outstanding balances not paid within 60 days may be turned over to a collection agency.
Limited personal information about you will be given out in order to collect outstanding balances. Fees are subject to change and will be discussed with you before the continuation of services.

Insurance Benefits: Some insurance companies will pay part of counseling fees, others will not. The Counseling Place will provide you a receipt you can send to your insurance company for possible reimbursement. **We will not accept your co-pay and file insurance for you.** Health insurance companies often require that one of our counselors diagnose your mental health and indicate that you have an "illness" before they will agree to reimburse you. I will inform you of the diagnosis when I fill out the form. Any diagnosis made may become part of your permanent insurance records. *Please check mental health benefits with your insurance company prior to beginning counseling.*

Cancellation/No Show Policy: Clients will be charged **$35.00** for canceled or unkept appointments unless the counselor is notified ***24 hours prior to the appointment time***. Exceptions may be made for emergencies, which include events happening outside of an individuals' control. **Please note that emergencies are subject to therapist discretion**. If you are late for an appointment, the session will still end at the scheduled time, and you will be charged for a full session. ***Balances for failure to show or a cancelled appointment must be paid before another session can be held.*** Please note that after 2 or more missed sessions, your case is subject to be closed under therapist discretion.

Legal Fees: In the event one of our counselors is requested to provide their services to an outside entity, the following fees will be assessed:

- $300 upfront for court services
- $100/hour for court time
- $150 for court preparation
- $35 for case copies
- $25 for case management

Agreement: My counselor has reviewed the above policies with me, and I understand these policies.
After reviewing the fee scale, I agree to pay $_____ per counseling session.

Crisis Lines: If at any point you are in crisis, please call one of these crisis lines where a trained crisis counselor will be available 24/7 to speak with you.
Suicide and Crisis Center of North Texas – 214-828-1000
National Suicide Prevention Lifeline – 1-800-273-8255
Crisis Text Line – Text HOME to 741741

* Adjustment of fees may be made under special circumstances at the discretion of the Executive Director

CITY OF RICHARDSON EMPLOYEE ASSISTANCE PROGRAM

FEE: City of Richardson employees **insured under their Health Insurance Plan** receive the initial, one-hour intake at no charge. Additional sessions are charged the co-pay of $20 per 50-minute session.

PAYMENT: Payment for the counseling session is **due at the time of the appointment**, unless prior arrangements have been made. Cash, credit/debit card or personal checks made out to "The Counseling Place" are acceptable for payment**. A returned check fee of $25 will be charged on any returned check**.

CANCELLATION POLICY: Clients will be charged $35.00 for canceled appointments unless the counselor is notified 24 hours prior to the appointment time. These sessions cannot be billed to the City. Exceptions may be made for emergencies. If you are late for an appointment, the session will still end at the scheduled time, and you will be charged for a full session. **Balances for failure to show or cancelled appointments must be paid before another session can be held.**

CONFIDENTIALITY: For billing purposes to the City of Richardson, clients are identified by number only. For example, you may be client #02-25 indicating you are the 25th client of the year 2002. Sessions are billed to the City of Richardson Human Resources Office monthly by date of service to arrange for the balance due under our contract agreement. See the "Counseling Agreement Form" for additional information about confidentiality of records. Please discuss with your therapist any concerns you may have regarding confidentiality.

AGREEMENT: My counselor has reviewed the above policies with me and I understand these policies.

VICTIM ASSISTANCE PROGRAM

You are eligible for counseling because you have been referred by the Richardson Police Department under one or more of the following conditions:

a) the Victim of a violent crime, or the family member of a Victim;
b) an information report taken by the Police Department for Family Conflict, Family Disturbance, or Family Violence;
c) an information report taken by the Police Department for suicidal thoughts or actions;
d) a family member or close friend has died, and you were directly affected.

The Richardson Police Department contracts with The Counseling Place to provide up to six (6) sessions of counseling per family member involved, per report at **NO CHARGE TO YOU**. However, the police department does not pay for appointments cancelled without 24-hour notice or for your failure to show for a scheduled appointment. **You will be charged a $35.00 fee for a late cancel or no-show**.

Should The Counseling Place, at their discretion, file a CVC claim on your behalf for counseling services rendered, you are still responsible for payment of the account balance. If for any reason you become ineligible for CVC benefits or for charges not paid by CVC or your insurance carrier (if applicable) to The Counseling Place for your account, you are still responsible for payment of services received from The Counseling Place. You also agree, if The Counseling Place files a CVC claim for you, to provide your insurance information at the time of the filing and to use CVC funds that you received for the purpose for which they are intended.

THE COUNSELING PLACE, INC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of its Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change its Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence,

and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient, under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. Please see fee sheet for file copy information. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer: Deborah Dobbs, Executive Director
Telephone: (469) 283-0242 Fax: (469) 519-4150
E-mail: debbie@counselingplace.org
Address: The Counseling Place
375 Municipal Dr., Suite 236
Richardson, Texas 75080

THE COUNSELING PLACE, INC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT *

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____

Please print **client's** name

_____

Signature (Use e-signature if submitting form through the TherapyPortal.)

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)

_____

_____

_____

ACKNOWLEDGMENT OF INFORMED CONSENT FOR COUNSELING

I hereby request that I, (*print client name*)_____ , be accepted for psychotherapy and mental health counseling as described to me. (*See below for consent for a minor*).

CONSENT:

1) I have given my authorization and freely consent to receive outpatient counseling services from The Counseling Place.
2) I understand that this consent is valid for 5 years and that I have the right to revoke the consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Provider has already taken action in reliance on this consent.
3) I understand that if I revoke this consent at any time, the Provider has the right to refuse me.
4) I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me on this document and contained in the Privacy Notice, then the Provider will not treat me.

COUNSELING SERVICES:

1) I have been given the "Counseling Agreement" which includes information regarding my rights and responsibilities as a client, limits of confidentiality with information discussed in session and my records, and contact information for the Texas Behavioral Health Executive Council.
2) I understand that counseling requires a mutual effort by the therapist and myself towards the agreed upon goals.
3) I have received information regarding the licensure and experience of my therapist.
    - The contact information for my therapist's supervisor (if under supervision) is as listed:
        1. Name: _____
        2. Phone Number: _____
        3. Address: _____
4) I have been given the opportunity to ask and have answered any questions regarding my counseling agreement with The Counseling Place, and understand as future questions may arise, I may address them with my therapist or The Counseling Place Executive Director.

FEES & SESSION INFORMATION:

1) I have been given the Counseling Fee Agreement Form for:
    - Counseling
    - Victims Assistance
    - City of Richardson
    - First Offender Program
    - Legal Services and Fees

    which outlines the cost of services from The Counseling Place. I understand that I am responsible for the payment of $_____ each session, and I understand and agree to adhere to The Counseling Place cancellation policy.
2) If understand that if I miss my scheduled appointment, and do not call the agency within 7-15 days, the agency will accept this at notice of termination of your contract and services. I understand that I am responsible for contacting my therapist regarding rescheduling and making appointments not otherwise scheduled or discussed during previous sessions. After 60 days without contact between client and therapist, The Counseling Place will close the client's file. Referrals will be given upon request.
3) I understand that service fees are subject to change, and that fee changes will be discussed prior to continuing services.

ASSESSMENTS:

1) I understand that the therapist may use assessments as screening tools to aid in measuring progress towards therapeutic goals. Therapists have been trained in how to use and interpret scores of assessments, abiding by state licensure guidelines and ethical codes. I understand that these assessments are not diagnostic tests and are only used to assist in the therapeutic process.

ACKNOWLEDGMENT OF INFORMED CONSENT FOR COUNSELING

COMMUNICATION:

1) By initialing or checking the boxes below, I am allowing The Counseling Place to communicate with me through the following forms of communication, to which I acknowledge are not secure forms of communication:

☐ Phone	☐ Text
☐ Voicemail	☐ Letter/Mail
☐ Email	

2) I acknowledge that if I communicate with my therapist in a manner that I have not initially approved, that I am allowing my therapist to communicate in the same format from that point forward. I acknowledge how we communicate outside of therapy is to the discretion of my therapist.
3) The Counseling Place offers **electronic appointment reminders**. Please indicate if you would like to receive reminders via text, call, and/or email. I understand that I can opt out of receiving appointment reminders at any time by contacting my therapist. I understand that I am an authorizing The Counseling Place to contact me regarding future appointments via:
   - ☐ Email: _____
   - ☐ Text* (Phone number): _____
   - ☐ Call** (Phone number): _____

   *Phone and text reminders will be issued from the phone number **512-580-7414.**
   **Our notification system does not allow us to send appointment reminders by phone call only. If you would like to receive appointment reminders by phone, please also select an alternate method.
4) I understand that if there are any safety concerns, communication may change at the discretion of the therapist.

COUNSELING FOR A MINOR CHILD, IF APPLICABLE:

1) I, _____, do hereby state that I am the biological parent and/or legal guardian of the client; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form. (If applicable, a copy of the Divorce Decree to support legal guardianship is required).

By signing below, I acknowledge that I have read, understand, and consent to the foregoing notice, and all of my questions have been answered to my full satisfactions in a way that I can understand.

_____
Signature of Client or Legal Guardian Date
(use e-signature if submitting form through the TherapyPortal)

_____
Signature of Therapist Date