**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** _____

Social Security No. _____ Drivers License No. _____ State _____

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

Home Address _____ Home Phone _____

City _____ State/Zip _____ Grade _____ School _____

Resides with _____ Relation to client _____ Legal Guardian? Yes / No

**Mother's Name** _____ Address _____

Best Contact Number_____ Email Address_____

Employer _____ Work Phone _____ Drivers License No. _____

**Father's Name** _____ Address _____

Best Contact Number_____ Email Address_____

Employer _____ Work Phone _____ Drivers License No. _____

**Stepmother's Name** _____ Best Contact Number_____

**Stepfather's Name** _____ Best Contact Number_____

Names and Ages of client's siblings _____

_____

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

Current Medications _____

Previous Medications_____

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

Seizures___ Accidents___ Arrests___ Substance Abuse___ Surgery___ Hospitalizations ___Other___

Please specify _____

_____

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

Client's usual mood _____ Any history of suicide attempts/ideation?_____ When _____

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

_____

_____

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 | _____ |

List additional illness, physical conditions or complaints:

_____

_____

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 _____

Socially, how does the client get along with other children? _____

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

List any organizations, teams, clubs the client belongs to _____

List any jobs or chores the client is responsible for _____

List other sports, hobbies, activities the client takes part in _____

What activities does the family enjoy doing together? _____

ACKNOWLEDGEMENT 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).

1) I have given my authorization and freely consent to receive outpatient diagnostic and counseling services from The Counseling Place.

2) I have received information regarding the licensure and experience of my therapist.

3) I have been given the "Counseling Agreement Form" which includes information regarding my rights and responsibilities as a client, and information regarding the limits of confidentiality of my records.

4) I understand that counseling requires a mutual effort by the counselor and myself towards the agreed upon goals.

5) I have been given the Counseling Fee Agreement Form for
   - o Counseling
   - o Victims Assistance
   - o City of Richardson
   - o First Offender Program

   which outlines the cost of services from The Counseling Place**. I understand that I am responsible for payment of $_____ each session** and I understand and agree to adhere to The Counseling Place **cancellation policy**.

6) 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 counselor or The Counseling Place Executive Director.

7) I understand that this Consent is valid for five years and that I have the right to revoke this 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.

8) I understand that if I revoke this consent at any time, the Provider has the right to refuse to treat me.

9) I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Provider will not treat me.

10) Counseling for a minor child, if applicable:
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.)

11) If you miss your scheduled appointment, and do not call our agency within 7-15 days, we will accept that as notice of termination of your contract and services. Referrals will be given upon request.

**I have read and understand 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

_____ _____
Therapist Date

## 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 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**. 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.

**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**
**Counseling Fee Agreement Form**

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 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.

**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 in 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 prior to beginning counseling.*

**CANCELLATION POLICY:** Clients will be charged **$35.00** for canceled appointments unless the counselor is notified ***24 hours prior to the appointment time***. 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 a cancelled appointment must be paid before another session can be held.***

**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:

- $500 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.

The Counseling Place Director – Debbie Walsh 972-744-4990
Suicide Crisis Line – 214-828-1000
Contact Crisis Line – 972-233-2233
Teen Crisis Center – 972-233-TEEN

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

# 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).

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## 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. If you request copies, we will charge you $0.35 for each page, $12.00 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. 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.

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## 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: Debbie Walsh, Executive Director
Telephone: (972) 744-4858 Fax: (972) 744-5988
E-mail: Debbie.Walsh@cor.gov
Address: The Counseling Place
P.O. Box 831078
Richardson, Texas 75042

# 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

_____
Date

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**For Office Use Only**

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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)

_____

_____

_____

# 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 (972-744-4858), 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 case is closed. Records of minors are disposed of seven years after the minor's eighteenth birthday. 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 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.

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 or the appropriate licensing board (LPC, LMFT, LCDC, and LMSW). Numbers are posted in the waiting area.