NEW CLIENT INFORMATION SHEET

Thank you for choosing **Elledge Counseling Associates** for your counseling needs. The following pages contain:

- Directions to the Counseling Center
- Personal Information Data Form
- Fee Scale and Counselor Experience
- Professional Disclosure and Informed Consent
- Financial Consent Statement and Fee Accountability
- Limits of the Counseling Relationship
- Notice of Privacy Practices
- Notice of Your Health Information Rights

Please complete each of the attached pages (one set each, if participating in marital or family counseling), and bring them with you to your first appointment.

If you have any questions, prior to your appointment, please feel free to call 972-268-3096.

Again, thank you for choosing **Elledge Counseling Associates**. We look forward to meeting with you soon.

DIRECTIONS TO THE COUNSELING CENTER

Phone: 972-268-3096

Red Oak

103 W. Red Oak Rd.
Red Oak, TX 75154

From Interstate 35 East, exit Red Oak Rd. and continue east toward Methodist St. We are located on your left in an unmarked, brick house across the street from Rock Community Church. Please park in the gravel parking lot and ring the doorbell if the door is locked when you arrive. Your counselor will be with you as soon as possible.

From FM 342, go east onto Red Oak Rd and cross the railroad tracks. We are located on your right in the unmarked, brick house across the street from Rock Community Church. Please park in the gravel parking lot and ring the doorbell if the door is locked when you arrive. Your counselor will be with you as soon as possible.

Duncanville

202 W. Center St. Ste. F
Duncanville, TX, 75116

From Hwy 20, exit Duncanville Rd./Main St. and continue south toward Camp Wisdom and make a left. Turn right on Main St. and veer right at fork to make a right onto Center St. We are located in the office complex across the street from Southwest Harvest Church in Suite F.

Grand Prairie

The Oaks Baptist Church
801 E. Interstate 20
Grand Prairie, TX 75052

From 360, merge onto Interstate 20 East. Exit Carrier Pkwy followed by a right turn onto Carrier Pkwy. Take the first left onto Westchase Dr. Continue through the stop sign and The Oaks Church will be on your right.

From Interstate 20 West , exit Carrier Pkwy followed by a right turn onto Carrier Pkwy. Take the first left onto Westchase Dr. Continue through the stop sign and The Oaks Church will be on your right.

From Interstate 20 East, exit Carrier Pkwy followed by a left onto Carrier Pkwy. Take the first left onto Westchase Dr. Continue through the stop sign and The Oaks Church will be on your right.

Midlothian

First Baptist Church Midlothian
1651 Midlothian Pkwy.
Midlothian TX, 76065

Take Highway 287 to Midlothian Parkway Exit. Exit Midlothian Parkway and turn south on Midlothian Parkway. The church will be located on your right. Enter through the awning farthest from Midlothian Parkway. To gain entrance, press buzzer to the far left of doorway and notify the receptionist of your appointment with counselor.

PERSONAL INFORMATION DATA FORM

Date: _____

Client Name _____ Date of Birth ___/___/____ Sex: M / F

Client Address _____ City_____

State _____ Zip _____

Phone: Home_____ May we leave a message at home? _____Yes _____ No

Work _____ May we leave a message at work? _____Yes _____ No

Cell _____ May we leave a message/text on your cell? _____Yes _____ No

Email: _____ May we contact you by email? ____Yes_____No

Employed: □ Yes □ No If yes, occupation: _____

If yes, Company name: _____ How long? ____

Have you had employment difficulties? □ Yes □ No If yes: □ current □ past

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Current Spouse's Name (if applicable) _____ Age ____ Years of Marriage? ____

Spouse's Phone (in case of emergency): _____

Previous Spouse's Name(s): _____ # of marriages ____

Names of children **If single, list parents and siblings**

First name	Last name	Age	Lives in your home
_____	_____	_____	□ Yes □ No □ Part time
_____	_____	_____	□ Yes □ No □ Part time
_____	_____	_____	□ Yes □ No □ Part time
_____	_____	_____	□ Yes □ No □ Part time
_____	_____	_____	□ Yes □ No □ Part time

Who can we contact in case of an **emergency**? (Must be an adult other than spouse)

Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

If you were referred to **Elledge Counseling Associates**, please indicate by whom: _____

May we acknowledge your referral: _____

If you were not referred to **Elledge Counseling Associates**, please indicate how you learned of our services:

__ First Baptist Red Oak __ The Oaks Baptist Church __ The Oaks Fellowship __ Creekwood Church

__ Southwest Harvest Church __ Internet Search __ Facebook __ Other (please indicate) _____

MEDICAL INFORMATION

How would you rate your current physical health? □ Excellent □ Good □ Fair □ Poor
Are you currently experiencing any physical problems (e.g. headaches, body aches, stomach problems)?

□ Yes □ No If yes, please explain: _____

Previous hospitalizations for medical reasons: Date: _____ Reason: _____

Date: _____ Reason: _____ Date: _____ Reason: _____

Medical conditions or disabilities: _____

Learning or other disabilities not listed: _____

Please list all **non-psychiatric** medications: (over the counter or prescription):

Medication	Dosage	Frequency

Have you ever abused prescription or non-prescription drugs?

□ Yes □ No If yes, which types? _____

COUNSELING AND PSYCHIATRIC INFORMATION

Have you had previous counseling? □ Yes □ No If yes, when? _____

Name and location of counselor: _____

If yes, for what reason? _____ For how long? _____

Have you ever been diagnosed or treated for any type of mental illness? □ Yes □ No

If yes, which type? _____

Has anyone in your family ever been diagnosed with or treated for any type of mental illness?

□ Yes □ No If yes, which type? _____

Have you ever attempted to commit suicide or homicide? □ Yes □ No
If yes, how? _____
Is there a history of suicide in your nuclear or extended family? □ Yes □ No
Are you presently having thoughts of harming yourself or others? □ Yes □ No

Please list all psychiatric medications:

Medication	Dosage	Frequency

Are you currently seeing a physician or psychiatrist? □ Yes □ No
Physician's Name: _____ City, State: _____ Phone: _____

Psychiatrist's Name: _____ City, State: _____ Phone: _____

REASON FOR SEEKING COUNSELING

What concerns have brought you to counseling today?

_____

Please rate the severity of your present concerns on the following scale.

Check one: □ Mild □ Moderate □ Severe □ Totally Incapacitating

What recent event prompted you to seek counseling at this time?

_____

_____

Where are your concerns causing the most difficulty for you? Please check all that apply**:**

□ Home □ Dating Relationship □Marriage □ Children □ Health □ Job □ Finances

□ Extended Family □ Relationship with God □ Other: _____

When did your present concerns begin to be a problem for you? _____

What concerns about you have been identified by others?

_____

Please check how often the following thoughts that occur to you:

1.	Life is hopeless.	___	Never	___	Rarely	___	Sometimes ___ Frequently
2.	I am lonely.	___	Never	___	Rarely	___	Sometimes ___ Frequently
3.	No one cares about me.	___	Never	___	Rarely	___	Sometimes ___ Frequently
4.	I am a failure.	___	Never	___	Rarely	___	Sometimes ___ Frequently
5.	Most people don't like me.	___	Never	___	Rarely	___	Sometimes ___ Frequently
6.	I want to die.	___	Never	___	Rarely	___	Sometimes ___ Frequently
7.	I want to hurt someone.	___	Never	___	Rarely	___	Sometimes ___ Frequently
8.	I am so stupid.	___	Never	___	Rarely	___	Sometimes ___ Frequently
9.	I am going crazy.	___	Never	___	Rarely	___	Sometimes ___ Frequently
10.	I can't concentrate.	___	Never	___	Rarely	___	Sometimes ___ Frequently
11.	I am so depressed.	___	Never	___	Rarely	___	Sometimes ___ Frequently
12.	God is disappointed in me.	___	Never	___	Rarely	___	Sometimes ___ Frequently
13.	I am disappointed with God	___	Never	___	Rarely	___	Sometimes ___ Frequently
14.	I can't be forgiven.	___	Never	___	Rarely	___	Sometimes ___ Frequently
15.	Why am I so different?	___	Never	___	Rarely	___	Sometimes ___ Frequently
16.	I can't do anything right.	___	Never	___	Rarely	___	Sometimes ___ Frequently
17.	People hear my thoughts.	___	Never	___	Rarely	___	Sometimes ___ Frequently
18.	I have no emotions.	___	Never	___	Rarely	___	Sometimes ___ Frequently
19.	Someone is watching me.	___	Never	___	Rarely	___	Sometimes ___ Frequently
20.	I hear voices in my head.	___	Never	___	Rarely	___	Sometimes ___ Frequently
21.	I am out of control.	___	Never	___	Rarely	___	Sometimes ___ Frequently

Please indicate which of the following are **<u>current</u>** issues for you. Check all that apply:

□ Not being able to say what you really think or feel

□ Under too much pressure and feeling stressed

□ Feeling down or unhappy/depressed mood

□ Excessive anxiety or worry

□ Withdrawing from others

□ Feeling inferior to others

□ Angry outbursts

□ Excessive fear of specific places or objects

□ Difficulty making friends

□ Difficulty keeping friends

- ☐ Suspicious feelings toward other people
- ☐ Afraid of being on your own
- ☐ Angry feelings
- ☐ Concerns about finances
- ☐ Feeling "numb" or cut off from emotions
- ☐ Concerns about physical health
- ☐ Concerns about emotional stability
- ☐ Tremors
- ☐ Blackouts or temporary loss of memory
- ☐ Insomnia (not being able to sleep)
- ☐ Loss of appetite/increased appetite
- ☐ Uncontrollable anxiety or worry
- ☐ Lacking self-confidence
- ☐ Feeling sexually attracted to members of your own sex
- ☐ Eating and then vomiting to control weight
- ☐ Excessive use of alcohol
- ☐ Abuse of non-prescription drugs
- ☐ Loss of interest in usual activities/lack of motivation
- ☐ Heart Palpitations
- ☐ Other: _____
- ☐ Feeling as if you'd be better off dead
- ☐ Feeling manipulated or controlled by others
- ☐ Difficulty making decisions
- ☐ Loss of interest in sexual relationships
- ☐ Feeling Fat
- ☐ Feeling distant from God
- ☐ Hallucinations
- ☐ Hypersomnia (sleeping all the time)
- ☐ Inability to concentrate while at school/work
- ☐ Crying spells
- ☐ Feeling "on top of the world"
- ☐ Nightmares
- ☐ Getting into trouble at school/work
- ☐ Obsessions or compulsions with specific activities
- ☐ Inability to control thoughts
- ☐ Feeling trapped in rooms/buildings
- ☐ Hearing voices
- ☐ Feeling that people are "out to get you" or that you are being watched
- ☐ Memory Problems
- ☐ Chest Pain/Pressure

What do you hope to gain from counseling?

_____

_____

STRENGTHS AND HELPS

What personal strengths do you feel you possess that may help you with your **current** difficulties?

_____

_____

Who or what has helped you cope with your **current** difficulties?

_____

_____

Who or what has helped you cope with **past** difficulties?

_____

_____

FEE SCALE AND COUNSELOR EXPERIENCE

Fee Scale

The fees for a 50-minute counseling session range in price from $25-$75 and are based on your counselor's education, experience, and office location. We accept exact cash or personal checks. We also accept credit cards; however, you will incur a processing fee in addition to your regular session fee. Please call for more details.

If your insurance company allows you to seek mental health benefits out of network, then there is a good chance they will reimburse you whatever percentage of "normal and customary charges" they have agreed to cover, less your deductible (if any). If you are part of an HMO, they will not pay for counseling through **Elledge Counseling Associates**, as we have chosen not to be on provider panels for any insurance company.

If you choose to seek reimbursement from your insurance company, we will provide you with a receipt for services that should suffice for you to file your own claim.

Counselor Experience

A Licensed Professional Counselor (LPC) in the state of Texas has completed a master's degree in psychology or counseling, passed the state exam, and completed 3,000 postgraduate hours of supervised experience with clients.

A Licensed Professional Counselor Intern (LPC Intern) in the state of Texas has completed a master's degree, passed the state exam, and is currently working on the required 3,000 postgraduate hours of supervised experience with clients.

A practicum student is at the end of their master's program working on the required hours of supervised counseling experience to complete their graduate degree.

PROFESSIONAL DISCLOSURE AND INFORMED CONSENT

I consent to take part in treatment with a counselor of **Elledge Counseling Associates**. I understand that developing a treatment plan with my counselor and working toward those goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment.

I am aware that I may stop treatment at any time. Yet, I am also aware that many times clients may feel like stopping therapy due to the pain or discomfort of addressing issues that are important to their well being. Therefore, I agree to talk with my counselor if I feel like quitting therapy before all my treatment goals are met.

Sessions last for 50 minutes. I also understand that if I am late to my appointment they will not run over into another client's time in that situation.

In the case of an emergency after regular business hours I may call the after-hours number to speak to the counselor on call. That number is 972-268-3096.

Confidentiality is the ethical right of all clients. However, there are certain exceptions, which supersede the confidentiality of the client-therapist relationship. Exceptions to Confidentiality: 1. The therapist makes an assessment of an impending suicide risk. (Chapter 611, Family Code) 2. A client reports past or present instances of the abuse or neglect of a child, elderly person, or mentally challenged person (Chapter 261, Family Code) 3. A client acknowledges committing abuse or neglect of a child, elderly person, or mentally challenged person either in the present or the past. (Chapter 261, Family Code) 4. There is a probability of imminent harm to the client or others. (Chapter 611, Sec. 004(a)(2) Health and Safety Code) 5. Counseling records may be released when they are subpoenaed by a court of law. I have read the preceding exceptions and understand that under the above stated circumstances the confidentiality of the client-therapist relationship is superseded. I understand that in such instances my therapist is bound ethically and legally to inform the proper authorities.

If any counselor from **Elledge Counseling Associates** is compelled to appear or testify on your behalf, either in a deposition or in court, I agree to pay that counselor for his or her time out of the office. The associated cost will be the counselor's regular session fee for up to 60 minutes of the counselor's time, with an additional regular session fee charged for every hour (or partial hour) thereafter. Billable time will include the average drive time to and from the Counseling Center office and the place of testimony.

Elledge Counseling Associates charges a counselor's regular session fee per hour to complete requested or subpoenaed documentation on your behalf. There is *no charge* for providing you with a standard receipt needed for insurance reimbursement purposes.

If the client is under the age of 18 years, I testify with my signature below that I have legal custody and authority and give my consent for _____ to receive counseling from the **Elledge Counseling Associates**.

By signing below you are stating that you have read and understood this policy statement. In addition, you consent to participate in evaluation and/or treatment. You have had your questions concerning this document answered to your satisfaction.

Client/Guardian Signature _____ Date _____

FINANCIAL CONSENT AND ACCOUNTABILITY STATEMENT

I am aware that I must call to cancel an appointment within 24 hours of that appointment in order to avoid financial responsibility for that session. It is my responsibility to call my counselor (day/night/weekend) to cancel my appointment.

Furthermore, I agree to the one time charge or debit to my credit/debit card in the amount of my regular appointment fee plus the $2 service charge, following any missed session or appointment cancelled with less than 24 hours notice. **Elledge Counseling Associates** is not required to notify me of this charge.

I am aware that payment is due at the beginning of each session. All checks should be made out to **Elledge Counseling Associates**. If paying by cash, only exact amounts will be accepted. If you do not bring exact cash the counselor is unable to make change and the excess will be applied toward your next session. If you choose to pay ahead for sessions be aware that we do not provide refunds for unused sessions.

If my check is returned for insufficient funds I agree to bring cash payment for the session and the NSF bank charge before my next scheduled appointment. If no cash payment is made I agree to a onetime credit/debit charge to my account plus the NSF fee and the $2 service charge to be made. **Elledge Counseling Associates** is not required to notify me of this charge.

If I fail to provide payment at the beginning of my session, my counselor is therefore unable to meet with me for our regularly scheduled session.

I understand that my counselor is unable to make further appointments with me until any balance on my account is paid in full.

I am aware that I must return any resources (CDs, DVDs, books, etc.) loaned to me. If I do not return the material(s) by the deadline given by the counselor, I agree to the onetime charge or debit to my credit card in the amount of the replacement cost of the material(s).

Credit /Debit Card Information:

Name as it appears on the card_____
Credit/Debit Card #_____ Expiration Date_____
Security Code on back of card _____
Cardholder's Zip Code _____

All Clients' Printed Names that this form applies to (including children):_____
_____

_____ _____ _____
Client Signature (Parent/Guardian if under 18) Printed Name Date

_____ _____ _____
Spouse's Signature (if counseling as a couple) Printed Name Date

LIMITS OF THE COUNSELING RELATIONSHIP

Although sessions with your counselor may be very intimate psychologically and interpersonally, the relationship is a professional relationship rather than a social one. Contact must be limited to sessions you arrange with your counselor.

Due to ethical guidelines, you are asked not to invite your counselor to social gatherings, offer gifts, ask your counselor to write references for you or relate to you in any way other than the professional context of the counseling sessions (this includes any interaction involving social networking sites).

Your counselor is required to keep the identity of clients confidential. Therefore, your counselor cannot and will not acknowledge you outside of counseling sessions unless you first acknowledge them.

Again, in order to maintain proper ethical standards, when the counseling relationship ends, the limitations of contact with your counselor must remain the same.

I have read and understand the Limits of the Counseling Relationship.

_____ _____

Client Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION
ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We are required by The Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by the practice, and of your individual rights and the practice's legal duties with respect to confidential information.

Ways in Which We May Use and Disclose your Protected Health Information:

We may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment and healthcare operations.

- **Treatment** means providing, coordinating, or managing mental health care and related services. *For example* – use or disclosure by the health care provider in training programs in which "students, trainees, or practitioners in mental health" learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.

- **Payment** means activities such as obtaining payment for the mental health care services we provide for you either from your insurance or another third party payer. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, and procedures performed.

- **Health care operations** include the business aspects of running our practice. *For example* – to evaluate our treatment and services, or to evaluate our staff's performance while caring for you.

We may contact you to provide appointment reminders or other services that may be of interest to you. We will disclose your protected health information to any person *you identify* that is involved in your care or payment for your care. For example - a family member, relative, close friend, a pastor or pastor's representative whom you have asked us to communicate with.

We will use and disclose your protected health information *when required to by federal, state, or local law*. There are certain situations in which, as a therapist, I am required by ethical standards to reveal information obtained during therapy to other persons or agencies - even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or are ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke an authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate you understand our operational use of your information for treatment, payment and healthcare operations as stated above.

_____ _____

Signature of Client/Responsible Party Date

NOTICE OF PRIVACY PRACTICES CON'T

Your Health Information Rights:

Although your records are the physical property of **Elledge Counseling Associates**, the information belongs to you. You have the following rights with respect to your information, which you can exercise by presenting a written request to our office manager.

You have:

- The right to request restrictions on certain uses and disclosures of your information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. For example – a request that we not identify the agency when we contact you. (i.e.- "This is **Elledge Counseling Associates** calling")
- The right to inspect and copy the information that we maintain about you. However, we ***may deny an individual access***, provided that the individual is given a right to have such denials reviewed, in the following circumstances:
  - a health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to ***endanger the life or physical safety of the individual or another person***;
  - the information makes ***reference to another person*** (unless the other person is a health care provider) and the health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
  - The request for access is made by the individual's personal representative and the health care provider has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to ***cause substantial harm to the individual or another person***.
  - If you wish to inspect or copy your information, you must submit your request in writing to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.
- The right to billing records.
- The right to revoke your consent to release information except to the extent that the agency has taken actions in reliance on the previously signed consent form.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. For example – at your regularly scheduled appointment at a church satellite office, or by e-mail or fax.
- The right to amend your information if you feel that it is incomplete or inaccurate. You must make this request in writing to your therapist stating exactly what information is incomplete or inaccurate and your reasoning to support your request. We will respond to your request with in sixty (60) days. In rare cases your request may be denied. For a complete description of Rights of Amendment, please contact our office manager.
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request.
- The right to file a complaint if you believe we have violated your medical information privacy rights. You have the right to file a written complaint to our office manager, or Executive Director, or directly to the Secretary of Health and Human Services

To file a complaint with our practice, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Brenda Elledge, Director, **Elledge Counseling Associates**, 103 West Red Oak Road, Red Oak, TX 75154. You should know there will be no retaliation for your filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. If and when one is available, you may request a written copy of a revised notice from this office.