Counseling Solutions

14138 HWY 195, KILLEEN, TX 76542
254-519-1144 (OFFICE) 254-519-1155 (FAX)
www.counselingsolutionskilleentx.net

PERSONAL INFORMATION & HISTORY

All information you provide here is held to the same standards of confidentiality as our therapy. Leave blank any question you would rather not answer. Please fill out this form prior to our first session.

Date _____ Referred By _____

Client Name _____ Male ____ Female ____

Address _____ City _____ Zip Code _____

E-Mail _____

Phone: Hm _____ Wk _____ Cell _____ Which would you prefer? _____

May I leave a message at Hm? _____ Wk? _____ Cell? _____

Age _____ Birthdate ____/____/____

Number, ages, & gender of children _____ Where do they live? _____

Employer/Occupation _____

Work Address _____ City _____ Zip Code _____

Contact in case of emergency: _____ Phone number _____

Please state the nature of your main concern: _____

_____

_____

Please rate how serious this concern feels to you: (Circle one) **Mild** 1 2 3 4 5 6 7 8 9 10 Severe

How long have you been experiencing this concern? _____

COUNSELING HISTORY AND RELATED INFORMATION

Are you currently receiving psychiatric services, counseling or psychotherapy elsewhere? ☐ Yes ☐ No

If Yes, with whom? _____

Have you had previous counseling or psychotherapy? ☐ Yes ☐ No

Previous therapist's name _____

Please describe your experience: _____

_____

Are you currently taking prescribed psychiatric medication (antidepressants, etc)? ☐ Yes ☐ No

If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication? ☐ Yes ☐ No

If Yes, please list: _____

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, when? _____ Length of hospital stay? _____

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HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____
   Please list current medications: _____
   _____

3. Are you having any problems with sleep? ☐ Yes ☐ No
   If yes, please explain: _____

4. How many times **per week** do you exercise? _____ Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? ☐ Yes No
   If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting
   Have you experienced significant weight change in the last 2 months? ☐ Yes ☐ No

6. Do you smoke or use tobacco? ☐ Yes ☐ No Please describe: _____
   Do you regularly use alcohol? ☐ Yes ☐ No Please describe: _____
   If yes, in a typical month, how much do you spend on alcohol? _____
   How often do you use other/recreational drugs? ☐ Daily ☐ Often ☐ Rarely ☐ Never ☐ Not any more
   If at all, please describe: _____

7. Have you had suicidal thoughts recently? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
   Have you had them in the past? _____

8. Are you currently in a romantic relationship? ☐Yes ☐ No
   If yes, how long have you been in this relationship? _____
   On a scale of 1-10, how would you rate the quality of your current relationship? _____
   Have you been engaged or married prior to this relationship? ☐Yes ☐ No
   If yes, please describe: _____
   _____

9. Current relationship status (please circle):
   Never married Separated Living together Married Divorced Widowed

10. What of the following have you experienced in the **past year**? (check all that apply)

Anger Management Issues	☐	Medical Issues	☐
Anxiety	☐	Memory Impairment	☐
Chronic Pain	☐	Obsessions/Compulsions	☐
Depression	☐	Parenting Issues	☐
Eating Disorder	☐	Phase of Life Problems	☐
Educational Problems	☐	Restlessness	☐
Family Conflict	☐	Sexual Dysfunction	☐
Financial Problems	☐	Sleep Disturbance	☐
Grief/Loss	☐	Social Discomfort/Shyness	☐
Intimate Relationship Conflict	☐	Spiritual Confusion	☐
Legal Problems	☐	Substance Abuse	☐
Loneliness	☐	Trauma (physical/emotional)	☐
Major Life Change	☐	Vocational Stress	☐

Other (specify): _____

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FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (immediate family members or relatives) experienced difficulties with the following?

Difficulty:		Family Member(s):	Received treatment?
Depression	☐ Yes ☐ No		
Bipolar Disorder	☐ Yes ☐ No		
Anxiety Disorders	☐ Yes ☐ No		
Panic Attacks	☐ Yes ☐ No		
Schizophrenia	☐ Yes ☐ No		
Alcohol/Substance Abuse	☐ Yes ☐ No		
Eating Disorders	☐ Yes ☐ No		
Learning Disabilities	☐ Yes ☐ No		
Trauma/Abuse History	☐ Yes ☐ No		
Suicide Attempts	☐ Yes ☐ No		

OCCUPATIONAL/EDUCATIONAL INFORMATION:

Are you currently employed? ☐ Yes ☐ No Status: ☐ Full-time ☐ Part-time
If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

Education (Highest grade completed - please circle):

0-5 6-8 9-12 GED High School College degree Graduate degree

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? ☐Yes ☐ No
If yes, what is your faith? _____
If yes, do you feel that your faith should be a significant part of your therapy? ☐Yes ☐ No
Please describe: _____
If no, do you consider yourself to be spiritual? ☐Yes ☐ No
Please describe: _____

GOALS/EXPECTATIONS

What goal(s) would you like to accomplish through counseling? _____

OTHER INFORMATION

What do you consider to be your strengths? _____

What do you like most about yourself? _____

How do you typically cope with problems in your life? _____

What have you already found to be helpful/not helpful with your current concern? _____

Client Signature _____ Date _____

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POLICIES, GENERAL INFORMATION & CONSENT
FOR TREATMENT & PSYCHOTHERAPY SERVICES

Please read and initial next to each paragraph:

_____ CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions *are confidential* and may not be revealed to anyone without your (client or parent's) written permission, except when required by law or for supervision purposes as previously stated.

* **When Disclosure Is Required By Law**: Where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled.

* **When Disclosure May Be Required**: Disclosure may be required if related to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain psychotherapy records and/or testimony from me. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgment when revealing such information. Records will not be released to any outside party unless authorized by all adult family members who were part of the treatment.

_____ EMERGENCIES: If there is an emergency during our work together, or after termination where I become concerned about your personal safety, the possibility of you injuring someone else, or you receiving proper psychiatric care, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and ensure that you receive proper medical care. For this purpose, I may contact the person you indicated on the biographical sheet. If you have an emergency or crisis, please indicate so clearly in your phone message. If you need help before I can return your call, you or someone you trust should call the emergency room at your local hospital, your medical doctor, or 911. If you have experienced suicidal thoughts or other severe psychiatric symptoms in the past, please inform me so we can develop a specific emergency plan.

_____ CONFIDENTIALITY OF COMMUNICATION: E-mail, fax and cell phone communication can be relatively easily accessed by unauthorized people and thus compromise your confidentiality. Please notify me if you decide to avoid or limit the use of any or all of these modes of communication. Please do not use e-mail or fax for communication in emergency situations.

_____ YOUR RIGHT TO REVIEW RECORDS: Both law and the standards of my profession require that I keep appropriate treatment records. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when releasing such information might be harmful in any way. In such cases, I will provide the records to an appropriate and legitimate mental health professional of your choice. Considering the above exclusions, if appropriate and upon your request, I will release information to any agency/person you specify unless I assess that releasing such information might be harmful in any way.

_____ LITIGATION LIMITATION: Due to the sensitive nature of therapy and the information shared and addressed, you agree that I am not obligated to supply any documentation, correspondence, or presence regarding any legal proceedings. Should you or your attorney desire any documentation or service for court/legal purposes, I must receive such request in writing and will have 2 weeks to give a response. I may decline the request if disclosure of the requested information may be harmful in any way to the client; no request will be acknowledged unless it is accompanied by the client's written permission. Any documentation, consultation, or testimony requests will incur a charge of $200 per hour. Testimony charges may include time spent traveling, preparing reports, attendance, and other case related costs.

_____ MEDIATION & ARBITRATION: Any disputes in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, initiation of arbitration. The mediator must be a neutral third party chosen by agreement of me and the client(s). The cost of such mediation, if any, shall be split equally. In the event that mediation is unsuccessful, any unresolved controversy related to the agreement should be submitted to and settled by binding arbitration in Bell County, Texas, in accordance with the rules of the American Arbitration Association in effect at the time the demand for arbitration is filed. If your account is overdue by more than 60 days and there is no agreed payment plan, I may use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection shall be entitled to recover a reasonable sum as and for attorney fees. In the case of arbitration, the arbitrator will determine that sum.

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_____ DUAL RELATIONSHIPS: Dual relationships should be avoided whenever possible, especially when ethics or your treatment progress may be in question. Therapy *never* involves sexual or any other dual relationships that may impair my objectivity, clinical judgment and effectiveness or could be exploitative in nature. I will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. discuss with you the potential benefits and difficulties that may be involved, and will discontinue the dual relationship if I find it interfering with the effectiveness of our therapeutic process. Should we encounter each other in any public setting, I will never approach you or even acknowledge you unless you first initiate contact so that I may protect your confidentiality and the nature of our professional relationship.

_____ THE PROCESS OF THERAPY: Participation in therapy can result in a number of benefits to you, including improving relationships and resolution of the specific concerns or symptoms that led you to seek therapy. Working toward these benefits requires effort on your part both in and outside of sessions. Although therapy has been shown to improve relationships and symptoms, it may create uncomfortable feelings in the short-term. For example, remembering or talking about unpleasant events, feelings, or thoughts can result in experiencing discomfort or strong feelings of anger, sadness, worry, insomnia, etc. Please inform me if such issues arise. I cannot guarantee what you will experience or benefits you might receive; however, it is most likely to be successful with your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. I will ask for your feedback and views on your experience in therapy, and will welcome your honest response. During the course of therapy, I am likely to draw from various psychological approaches according to the problem that is being treated and my assessment of what will best benefit you. These approaches include cognitive-behavioral, solution-focused, family systems, or psycho-educational therapy.

_____ MINOR CLIENTS: Parents have a right to receive progress reports on their child's counseling. However, personal information shared by a child during an individual session will be kept confidential unless it involves imminent danger to the child or someone else. Young people will not confide in a counselor if they believe that personal information will be revealed to their parents. If applicable, I must receive a copy of the most recent divorce decree or custody order at our first session; this is to ensure proper consent, confidentiality and disclosure of information. All parent/guardian parties must at least be informed of treatment, and all with custody rights must consent to treatment of minor at or prior to the first session. Exceptions to parental consent may apply to minors 16 years or older who present for emergency counseling regarding sexually transmitted diseases, substance abuse, pregnancy issues, and/or are emancipated.

_____ DURATION & TERMINATION: The duration of treatment depends entirely on your presenting concerns, treatment goals, and effort toward those goals in and outside of sessions. I typically discuss duration more specifically with the client in the 3rd or 4th session, depending on factors such as duration limitations by your insurance carrier. I request a two-session notice before therapy is terminated in order to process gains made during treatment, as well as issues to be addressed in the future either by me or another therapist.

_____ PHONE CALLS & E-MAIL: In the event that you need to contact me between sessions, 10 minutes per week is allowed without charge. After the first 10 minutes there will be a charge prorated according to your session fee. I check my phone and e-mail messages between 9:00 a.m. and 5:00 p.m., Tuesday through Thursday. Messages left late in the day may be returned on the next business day. You may e-mail me to make, cancel, or reschedule an appointment, to make brief reports about your progress, or to ask simple questions that can be answered in a few words. Therapy issues, questions, or crises will not be addressed by e-mail. Please see above for emergency protocol.

_____ CANCELLATION: An appointment is considered cancelled when not attended at the agreed time/date, and not rescheduled and attended within the same calendar week as the original appointment. If you cancel your appointment two weeks in a row, that time slot will be available to other clients. A late fee/no show fee will be charged for all appointments cancelled less than 24 hours before the scheduled time. Payment is due for any missed appointment at the beginning of the next session.

CLIENT/GUARDIAN: I have carefully read, understand, and agree to comply with the above policies and information, and consent for treatment and psychotherapy services.

Client Name (Print) _____ Date_____

Signature _____

Client Name (Print) _____ Date_____

Signature _____

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PROVIDER STATEMENT

(To be completed by provider)

I have discussed the above issues and policies with the client. My observations of this person's behavior and responses give me no reason to believe that he/she is not fully competent to give informed and willing consent to treatment.

Signature_____ Date_____

Terry A. Strong M.A., LPC

Jacquiline Paprzycki, M.S. LPC, DBT

Lisa Peterson, LMFT, LPC

Sheila Hoogandam, M.S LPC

If psychotherapy services are not rendered in a professional and ethical manner, you may file a complaint with the Texas State Board of Examiners of Professional Counselors/MFT:

Texas Board of Examiners of Professional Counselors
Texas Department of State Health Services MC-1982
1100 West 49th Street
Austin, Texas 78756-3183, USA
E-mail: lpc@dshs.state.tx.us
Telephone: (512) 834-6658
Fax: (512)834-6677

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Please Read and Sign/Date ALL of the following whether they apply to you or not. This will insure you know our policies.

Release of Medical Information:
I authorize the release of any personal information concerning my (or my child's) mental health care, advice and treatment necessary to process this insurance claim. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____

Assignment of Benefits:
I authorize the release of medical benefits to Counseling Solutions as described on insurance claims forms. I also understand that this assignment of benefits is irrevocable and a photo copy shall be considered as legal and binding as the original.

Signature _____ Date _____

Payment Policy:
All payment for professional services rendered are due at the time of service unless insurance is applicable. We will file insurance, but all co-pays, co-insurance and deductibles are due at the time of service. Non-covered services and balances after insurance payment will be billed to the patient. I understand that I am responsible for the total changes of services rendered.

Signature _____ Date _____

Fee Policy: IMPORTANT PLEASE READ!

1. There will be a **$40.00** charge for all no shows (A no show/late cancel is any appointment that is not cancelled with at least **24 hour notification**). Fee must be paid at the next appointment. After two no shows/late cancelations you can be dropped as a client from our facility.
2. A reasonable fee will be charged for writing of letters. Fees will be set by each therapist.
3. A **$25.00** fee will be charged for the copy of your medical records.
4. court fee of **$200.00** per hour will charged to the client. This fee is accessed if you need the therapist to go to court.
5. Should any balance become **30 days** or more past due the account **will** be sent to a collections agency. An additional charge of **40%** will be added to the balance for collection fees.
6. A **$40.00** fee will be charged for NSF checks.

Signature _____ Date _____

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HIPPA - CONSENT FORM FOR CLIENTS

Counseling Solutions

I consent to the use or disclosure of my protected health information by Counseling Solutions, for the purpose of Treatment, Payment and Health Care Operations.* I have received a copy of the Notice of Privacy Policies and understand I have a right to review prior to signing this document.

I UNDERSTAND:

- Service to me may be conditioned as to how my protected health information is used or disclosed to carry to treatment, payment or health care operations of the practice. If Counseling Solutions agrees to a restriction that I request, the restriction is binding on Counseling Solutions.
- I have the right to revoke this consent, in writing, at any time, except to the extent that Counseling Solutions has taken action in reliance on this consent.
- My protected health information, including my demographic information, is collected from me, created or revised by my physician, another health care provider, a health plan or a future physical or mental health or condition and identifies me; or there is a reasonable basis to believe the information may identify me.

THE NOTICE OF PRIVACY PRACTICE DESCRIBES:

- The types of uses and disclosures of my protected health information that will occur if my treatment, payment of my bills or in the performance of health care operations performed by Counseling Solutions.
- My rights and the duties of Counseling Solutions with respect to my protected health information.

Counseling Solutions reserves the right to change its privacy practices. All current or revised notices can be obtained by visiting our office located at 14138 State Highway 195, Killeen, Texas 76542.

Full Name (PLEASE PRINT)

Address City State Zip Code

Signature of Parent/Guardian Date

*Treatment includes activities performed by a health care provider, office staff, and other of health care professionals providing care to you, coordination or managing your care with third parties, and consultation with and between other health care providers. Payment includes activities involved in determining your eligibility for health plan coverage.

billing, and receiving payment for your health benefit claims, and utilization management activities, which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization. Health Care Operations includes the necessary administrative and business functions of our office.

ACKNOWLEDGEMENT OF REVIEW OF PRIVACY PRACTICES AND STATEMENT OF UNDERSTANDING

I have reviewed Counseling Solutions' Informed Consent to Treatment and limits of confidentiality statement as well as the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of the Notice and Privacy Practices if I choose.

I also give permission and consent to Counseling Solutions, for the administration of any and all treatment determined by the therapist. I understand that primary treatment procedures will be determined as an agreement between myself and the therapist and will identify major goals and alternative treatment options.

Signature _____ Date _____

SERVICE PROVIDER'S STATEMENT

(To be completed by provider)

I have inquired to insure that the patient understood the above description of the Limits of Confidentiality and informed the patient if I am under supervision and by whom.

Signature _____ Date _____