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LAKE POINTE COUNSELING CENTER
Confidential Adult Intake Information

Date: _____

Patient Information:

Full Legal Name: _____ Date of Birth: _____ Age: _____

Home Address: _____ City/State/Zip: _____

Email address: _____ Phone: _____

May we contact using: email phone text

What is your relationship status?

Single Married Divorced Separated Cohabiting Widowed Blended

Spouse / Partner: _____

Emergency Contact Name: _____ Relationship to Client: _____

Emergency Contact's #: _____

Do you currently have a church home? No Yes If yes, where do you attend: _____

Are you a member of Lake Pointe Church? No Yes

Other Persons currently living in your home:

<u>Name</u>	<u>Age</u>	<u>Gender</u>	<u>Relationship</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Financially Responsible Party: _____ Relationship to Client: _____

Name: _____

Credit Card #: _____ Exp. Date: _____ CVC: _____

PATIENT SERVICES AGREEMENT

GENERAL INFORMATION: This Agreement contains information about privacy and patient rights. As required by law, your Notice of Privacy Practices for use and disclosure of Private Health Information (PHI) is available from our office. The law requires that we obtain your signature acknowledging that you were provided this information. Your signature represents a revocable agreement between us. A written revocation will be binding on us unless Lake Pointe Counseling has taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

MENTAL HEALTH SERVICES: The nature of psychotherapy varies depending on the personalities of the therapist and patient. In order for the therapy to be successful, you will have to work on things talked about both during sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. Growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. One might hope this would balance out with the discovery of joy relief and freedom as well. Benefits of psychotherapy include better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience. Your therapist will evaluate your needs and offer treatment recommendations. You can discuss any questions you may have. If you have persistent doubts, your therapist will help you get a second opinion.

COUNSELING RELATIONSHIP: Your relationship with any therapist is a professional and therapeutic one. It is imperative that your therapist does not have any other type of relationship with you. Personal and/or business endeavors undermine the effectiveness of the therapeutic relationship. Your therapist cares about helping you but is not in a position to have a social, personal, or business relationship with you of any kind.

EMERGENCY CALLS: After business hours, we provide an answering machine on which you can leave a message for return calls. We will make every attempt to return your call within 24 hours with the exception of weekends and holidays. If you feel that you can't wait for a return call, contact your family physician, 911, or the nearest hospital emergency room. It is not Lake Pointe Counseling Center's policy to text, email or do phone sessions with clients. If you choose to do so, you waive your right to confidentiality.

Initial: _____ **Initials:** _____

CONFIDENTIALITY: Confidentiality is defined as keeping private the information shared by you, the client, and your therapist. As a client, you have the right to withhold or release information to other individuals or agencies. No information will be released to anyone not performing business for this office without your consent unless mandated by Texas law. You may request an accounting of all disclosures made of your record, and, whenever it is possible, any disclosure of your healthcare information to an outside individual or agency will be discussed with you prior to disclosure.

Please be advised that, although protecting your confidentiality is a priority for your therapist, Texas law mandates several exceptions to your right to confidentiality.

LIMITS ON CONFIDENTIALITY: The law protects communications between a patient and a mental health provider. Typically, information about your treatment is only released to others if you sign a written authorization form. This signed Patient Services Agreement provides consent for the following:

- Your therapist may need to consult other professionals about a case. Every effort is made to avoid revealing the identity of patients. The other professionals are also legally bound to keep the information confidential. If you don't object, you will not be told about these consultations unless your therapist feels that it is important to your work together.
- Your therapist practices with other mental health professionals and Lake Pointe Counseling employs administrative staff. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member or signed consent of patient.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.
- If a patient seriously threatens to harm himself/herself, your doctor or therapist may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. There are some situations where your therapist may disclose information without either your consent or authorization:
 - If you are involved in a court proceeding and a request is made for information concerning your treatment, such information is protected by law. Your therapist cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
 - If a government agency requests information for health oversight activities, we may be required to provide it.
 - If a patient files a complaint or lawsuit against a therapist of Lake Pointe Counseling, your therapist may disclose relevant information regarding that patient for the purpose of legal defense
 - If a patient files a worker's compensation claim, your therapist must, upon request, provide records relating to treatment or hospitalization for which compensation is being sought.

There are some unusual situations in which your therapist is legally obligated to take actions necessary to protect others from harm and may have to reveal some information about a patient's treatment.

If your therapist believes that a child has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, a report must be made to the appropriate governmental agency. Your therapist may then be required to provide additional information.

If a therapist believes that the patient will inflict imminent physical, mental, or emotional harm upon himself/herself, or others, the therapist may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient. If such a situation arises, or therapist will make every effort to discuss it with you before taking any action and will limit disclosure to what is necessary.

If you have questions regarding confidentiality, you should bring them to the attention of your therapist and discuss this matter further. Please be advised that by signing this information and consent form, you are giving your consent to the therapist to share confidential information with all persons mandated by law, and you are releasing and holding harmless the therapist from any departure from your right of confidentiality that may result.

Initials: _____ **Initials:** _____

CLIENT RECORDS: Protected Health Information (PHI) about you is kept in two sets of records. (1) Your Clinical Record includes information about your reasons for seeking therapy, your diagnosis, treatment goals, medications, your progress, your medical and social history, your treatment history, any past treatment records received from other providers, reports of professional consultations, billing records, and reports that have been sent to anyone, including reports to insurance carriers. Typically, you may examine and/or receive a copy of your Clinical Record, you have a right of review.

(2) Psychotherapy Notes assist your therapist in providing treatment. They contain the sensitive information that you may reveal. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. You may examine and/or receive a copy of your Psychotherapy Notes unless your therapist determines that release would be harmful to your physical, mental or emotional health.

PATIENT RIGHTS: You have some rights regarding your Protected Health Information including requesting that your therapist amend your record; requesting restrictions on what is disclosed to others; requesting an accounting of most disclosures of protected health information that you have not authorized; determining the location to which protected information disclosures are sent; having complaints about your therapist's policies and procedures recorded in your records; and a paper copy of this Patient Services Agreement, the attached Notice form, and our privacy policies and procedures.

MINORS & PARENTS: The law allows parents to examine a minor child's treatment records unless the treatment is for suicide prevention, chemical addiction, or sexual, physical or emotional abuse. Because privacy is often crucial to success, your therapist will typically provide parents only with general information the child's treatment. Before giving parents any additional information, the therapist will discuss the matter with the child.

PAYMENT FOR SERVICES: Payment is due at the time services are rendered, after each session. The fee is \$100 per session. Lake Pointe Counseling Center accepts cash, checks and most credit cards. Fees incurred for returned checks are the client's full responsibility.

Initials: _____ **Initials:** _____

INSURANCE: Lake Pointe Counseling Center does not bill insurance, nor are we in network with any insurance companies. We can provide a statement for you containing CPT and a diagnosis code. This statement may be submitted by the client to insurance carriers for reimbursement should the carrier accept out of network claims. Clients are responsible for all charges whether or not they are covered by insurance.

Initials: _____ **Initials:** _____

ADDITIONAL SERVICES/ADDITIONAL COSTS: Although it is the goal of the therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. In the event disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records. If your therapist is requested or mandated to prepare and give testimony in legal proceedings, you must pay for all the professional time as indicated: court fee \$500 for a half day paid seven (7) days in advance of the court proceeding; each additional hour to appear in legal proceeding is \$200; each additional hour of preparation time is \$100; and reimbursement for transportation and parking costs.

Initials: _____ Initials: _____

REPORT PREPARATION FEES: We do not fill out paperwork for FMLA, Short-Term Disability, Long-Term Disability, Worker’s Compensations claims, or write letters for Emotional Support Animal requests. These types of requests should be filled out specifically **by your medical doctor**. This paperwork requires a medical diagnosis from a medical doctor. Counseling services do not serve as a substitute or bypass medical care that is required for these certain types of documents to be completed.

CANCELLATION FEE: Therapy appointments are usually 45 minutes in length. Your therapy time is reserved for you. *Please call to cancel or reschedule at least 24 hours in advance.* If 24 hours notice is not given or a “no show” occurs, *you will be charged a customary \$100 fee* for the missed appointment. Insurance does not cover charges for missed sessions.

Initials: _____ Initials: _____

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE HAD THE OPPORTUNITY TO READ AND RECEIVE A COPY OF THE HIPAA PRIVACY NOTICE DESCRIBED ABOVE.

A copy of this document is available upon your request or accessible at www.lakepointe.org

Date: ____ - ____ - ____

Client or Parent/Guardian **SIGNATURE:** _____
SIGNATURE: _____

If the patient is under age or has a guardian appointed by the court, this agreement must be signed by the patient's legal guardian. If the agreement is signed by a personal representative of the patient, a legal description of such representative's authority to act for the patient must be provided.

Lake Pointe Church Counseling Center
HIPPA – Notice of Privacy Policies

This notice describes how your private health information may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Private Health Information may be used and disclosed in the following circumstances:

1. When required by any state or federal law, including case of abuse and neglect.
2. When required for any specialized government or military functions including active personnel, reservists, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
3. When used for any clerical purposes and necessary chart audits by managed care companies.
4. In accordance to Texas Health & Safety Code, Chapter 611, records of release protocol.

As a client, you have rights to your Private Health Information, including:

1. The right to review your records or receive a copy of your records at any time by signing a formalized, written request. However, under certain rare circumstances your request can be denied. Written requests for records will be honored within 15 days after receiving a proper written request that has been filed with Lake Pointe Counseling Center.
2. The right to request information of any party that has requested information pertaining to your Private Health Information.
3. The right to receive confidential information regarding your private health information.
4. The right to revoke this consent in writing; however, this will not affect any information already disclosed.

Lake Pointe Counseling Center has the responsibility to:

1. Make you, the client, aware of the Lake Pointe Counseling Center Privacy Policies which is available on our website or we have available copies upon request at our office.
2. To make the necessary changes to the Privacy Notice that are required by law.
3. If you as the client feel your privacy has been violated, you have the right to contact the US Department of Health & Human Services Office of Civil Rights at www.hhs.gov/ocr/hipaa/. Or, you may file a complaint to the Texas State Board of Examiners of Professional Counselors in Austin, Texas. Main Numbers: 512-776-7111 or 1-888-963-7111.

I have reviewed and understood this notice.

Client: _____

Client signature: _____

Today's Date: _____

LIFE FUNCTIONING INVENTORY

Name: _____ Date: _____

Presenting Problem:

1. Briefly describe the problem or concern you most wish help with currently:

2. How would you rate the intensity of the problem or concern that led you to seek professional services?

Extremely Intense Moderately Intense Not Intense

3. Approximately how long have you had the current problem or concern? _____

4. In what ways have you attempted to cope with this problem?

Stressors: Please indicate any issues that you (the client) are having difficulty with:

- | | | |
|---|--|---|
| <input type="checkbox"/> Anger/frustration | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Difficulty Relaxing | <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Helplessness | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Inferiority Feelings | <input type="checkbox"/> Isolation/withdrawal |
| <input type="checkbox"/> Job Stress | <input type="checkbox"/> Lack of enjoyment of life | <input type="checkbox"/> Loss of Employment |
| <input type="checkbox"/> Marital issues | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Obsessive thoughts/behaviors |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Parenting issues | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Racing Heart | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Self-Control issues | <input type="checkbox"/> Stress | <input type="checkbox"/> Thoughts of hurting others |
| <input type="checkbox"/> Thoughts of hurting self | <input type="checkbox"/> Weight Issue | <input type="checkbox"/> Worthlessness |

Mental Health Information:

Have you previously received any type of mental health services in the past?

No Yes Previous Counselor's name: _____ Phone: _____

Issues of Concern: _____

Are you currently taking any prescription medications? No Yes If yes, please list below:

Please list any inpatient treatment you may have received: _____

Name of Primary Physician: _____ Phone number: _____

Have you ever been prescribed medication for psychiatric reasons? No Yes

If yes, please specify the following:

Name/dose of medication: _____

Date of prescription: _____

Duration of medication: _____

Physician who prescribed medication: _____

Have you ever considered or attempted suicide? No Yes, explain: _____

Have you ever intentionally inflicted harm upon yourself? No Yes Nature of Harm: _____

General Health Information:

How would you rate your current physical health? Poor Good Very Good

Please list any specific health problems you are currently experiencing: _____

How would you rate your current sleep habits: Poor Good Very Good

Please list any specific problems you are currently experiencing: _____

How you currently experiencing overwhelming sadness, grief or depression? No Yes

How Long? _____

Are you currently experiencing anxiety, panic attacks or any phobias? No Yes

How Long? _____

Are you currently experiencing any chronic pain? No Yes Please describe: _____

In regard to alcohol: I never drink I consume ___ drinks per week I drink on social occasions

I am a recovered alcoholic, sober _____ years _____ months _____ weeks _____ days

Has anyone close to you ever been annoyed by your drinking? No Yes

Do you consider your alcohol consumption to be a problem? No Yes

Have you tried to cut down on the amount of alcohol you consume? No Yes

In regard to drugs: I have never used drugs I currently use I used to use but quit ___ years ago

Do you consider this drug use to be a problem? No Yes

Have you ever experienced legal problems? No Yes Nature of Problem: _____

What significant life changes or stressful events have you experienced: _____

Have you ever experienced any form of traumatic experience? No Yes When? _____

Nature of experience? _____

Have you ever experienced sexual assault, unwanted sex or uncomfortable touching?

Frequently a few times once never unsure

How does your future look to you? poor fair neutral good excellent

What do you hope to accomplish through counseling? _____

Is there anything else you would like your counselor to know about you? _____

Your signature below:

Client Signature