Cooper Counseling Services, PLLC
Misty Cooper, MS, LPC-S
10310 N 138th E Ave, Suite 201
Owasso, OK 74055
(405) 254-6081

Hello,

Welcome to Cooper Counseling Services, and thank you for allowing me to work with you!

Before your appointment, please read the following practice policies and complete the attached paperwork.

Client Services Contract
Adult Intake Form
HIPAA Privacy Practices
Professional Disclosure Statement

It's important this is completed and turned in at your first appointment. I'm happy to discuss the details with you and answer any questions you may have before we begin our initial session.

I take a relaxed and nurturing approach to counseling. My main focus is an integrated approach to therapy by utilizing a variety of orientations and therapies based on the client's individual needs. I provide a safe, non-judgmental atmosphere for clients to heal and move forward.

My office is located in the State Farm building behind Lanes at Coffee Creek Bowling Alley. My office is located at the top of the stairs in Suite 201. I own and operate my own private practice, Cooper Counseling Services, PLLC. I rent an office in a group practice of other therapists who also own their own businesses. Given this, I share a common waiting room with other independent practitioners. There may be times when you may see other clients who are waiting to be seen in this common area. If you wish for absolute privacy, please talk to me about arranging a private exit and entry strategy for your discretion.

I look forward to meeting with you,

Misty Cooper, MS, LPC-S
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10310 N 138th E Ave, Suite 201
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Phone: 405-254-6081
www.coopercounselingservice.com

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CLIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

THERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you hope to address. There are many different methods I may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

PROFESSIONAL FEES

My private pay hourly fee is $150 for a 55 minute session. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. I charge $200 per hour for professional services I am asked or required to perform in relation to your legal matter. I also charge a copying fee of $25 for records requests.

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BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when such services are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I will release regarding a client's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

CANCELLATION POLICY

Since the scheduling of an appointment involves the reservation of a time set aside especially for you, a minimum of 24-hour notice is required for the cancellation or rescheduling. Appointments are in high demand, and your advance notice will allow another client access to that appointment time. Cancellations made prior to this window are rescheduled with no penalty. Cancellations made without 24 hours' notice but prior to the start of the session incur a $50 late-cancellation fee. No-shows or cancellations made after the start of the session incur the full session fee of $150. **This charge is NOT covered by insurance.**

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. It is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.***

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

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CONTACTING ME

I am often not immediately available by telephone. Though I am usually in my office between 9 AM and 5 PM, I will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voice mail, that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact 911 or your family physician or go to the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

ELECTRONIC COMMUNICATION POLICY

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

Email Communications/Text Messaging

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication. Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages unless it is in regards to setting or changing an appointment.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter, Snap Chat, Instagram or Facebook.

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CONFIDENTIALITY

In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person or disabled person is being abused or has been abused, I must make a report to the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney.

Your signature below indicates that you have read the information in the outclient services contract and agree to abide by its terms during our professional relationship.

CLIENT SIGNATURE _____ DATE _____

THERAPIST SIGNATURE_____ DATE: _____

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Adult Intake Form

Name_____Date_____

Address _____City _____ State____ Zip _____

Date of Birth _____ Primary Care Physician_____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

What are the problem(s) for which you are seeking help?

1._____

2._____

3._____

What are your treatment goals?

_____

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed Mood	**( ) Racing thoughts**	**( ) Excessive worry**
( ) Unable to enjoy activities	**( ) Impulsivity**	**( ) Anxiety attacks**
( ) Sleep pattern disturbance	**( ) Increase risky behavior**	**( ) Avoidance**
( ) Loss of interest	**( ) Increased libido**	**( ) Hallucinations**
( ) Concentration/forgetfulness	**( ) Decrease need for sleep**	**( ) Suspiciousness**
( ) Change in appetite	**( ) Excessive energy**	**( ) Excessive guilt**
( ) Fatigue	**( ) Increased irritability**	**( ) _____**
( ) Decreased libido	**( ) Crying spells**	**( ) _____**

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Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____

Past Medical History

Allergies _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, non-psychiatric hospitalization, or surgeries: _____

_____

Do you have any concerns about your physical health that you would like to discuss with me? ( ) Yes ( ) No

Date and place of last physical exam: _____

Is there any personal or family medical history that I need to know about? ( ) Yes ( ) No If yes, please explain:

_____

_____

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Past Psychiatric History:

Outclient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated By Whom

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

_____

_____

Past Psychiatric Medications: If you have ever taken any psychiatric medications please indicate, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Medication Dates Dosage

Response/Side Effects

_____

_____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem? _____

_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol? _____ What is the least number of drinks you will drink in a day? _____ What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

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Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No If yes, which ones?

_____

Have you ever abused prescription medication? ( ) Yes ( ) No If yes, which ones and for how long?

_____

_____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No Where did you grow up? _____

List your siblings and their ages: _____

_____

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with?_____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her:

_____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

Who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.

Please describe when, where and by whom: _____

_____

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____Major? _____

What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

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Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Are you sexually active? ( ) Yes ( ) No How would you identify your sexual orientation?

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other:

_____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____

How long? _____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____

_____

Describe your relationship with your children: _____

List everyone who currently lives with you: _____

_____

Is there anything else that you would like us to know?

_____

_____

_____

_____

Signature_____Date_____

Emergency Contact _____ Telephone # _____

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*****CLIENT COPY*****

HIPAA PRIVACY PRACTICES (PRIVATE PAY AND INSURANCE)

This notice describes Medical Information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how Cooper Counseling Services, PLLC may use and disclose your PHI in accordance with applicable law and the ACA Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Cooper Counseling Services, PLLC is required to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. Cooper Counseling Services, PLLC is required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. Cooper Counseling Services, PLLC will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

How Cooper Counseling Services, PLLC may use and disclose Health Information about you.

For treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may discuss PHI to any other consultant only with your authorization.

For payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only discuss the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing of typing services) provided we have a written contract with the business that requires it to safeguard, the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. We may use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services.

Required by Law: Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations (such as the counseling licensing board or the health department.)
- Required by Court Order.
- Necessary to prevent a serious or imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a p
- Verbal Permission: We may use or discuss your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise these rights, please submit your request in writing to: Cooper Counseling Services, PLLC at 10310 N. 138th East Avenue Suite 201. Owasso, OK 74055.

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Notice of Privacy Practices

Client Name: _____
Date of Birth: _____

I hereby acknowledge that I have received and been given an opportunity to read a copy of Cooper Counseling Services PLLC's Notice of Privacy Practices. I understand that if I have any questions regarding the notice of my privacy rights, I can contact Cooper Counseling Services, PLLC at: (405) 254- 6081 or misty@coopercounselingservice.com.

Client Signature: _____
Parent/Legal Guardian Signature:_____
Date: _____

You may refuse to sign this acknowledgment if you wish.
___Client refuses to Acknowledge receipt
Reason given_____

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Licensed Behavioral Practitioners
Licensed Marital and Family Therapists
Licensed Professional Counselors

State Board of Behavioral Health Licensure
3815 N. Santa Fe, Ste. 110
Oklahoma City, OK 73118
Telephone: (405) 522-3696
Fax: (405) 522-3691
www.ok.gov/behavioralhealth

STATEMENT OF PROFESSIONAL DISCLOSURE

Please check the appropriate license: ❑ **LPC** ❑ **LBP**

I am required by law to furnish this document to you. It requires that I inform you about my professional training, orientation /techniques, experience, fees and credentials. I am licensed to practice my profession by the State Board of Behavioral Health Licensure.

My license number is **LPC** 5580 **LBP** _____

The licensing website is **www.ok.gov/behavioralhealth** where you can access the law and regulations which govern my license. I will furnish you with printed materials about the requirements of my licensure if you so desire. You may contact (without giving your name), the State Board of Behavioral Health Licensure at:

State Board of Behavioral Health Licensure
3815 N. Santa Fe, Ste. 110
Oklahoma City, OK 73118
Telephone: (405) 522-3696
www.ok.gov/behavioralhealth

Licensee's Printed Name: Misty Cooper, MS, LPC-S

Licensee's Signature: Misty Cooper, MS, LPC-S **Date:** _____

The above-designated licensee has satisfactorily supplied me with information regarding his/her practice, licensure and professional development.

Client's Signature: _____ **Date:** _____