Soul Academy, PLLC Intake Form

Please complete all information, including any initials. NOT completing all required information may result in a delay in your treatment. If you have already scheduled an appointment, any information that is missing or inaccurate may cause your appointment to be cancelled until the missing or inaccurate information is completed/corrected.

NOTE: All personal information is held securely in accordance with the appropriate legislation confidentially and treated appropriately.

You have two options:
You can complete the form electronically or you can print, complete, and email the form back to susan@soulacadeymus.com. (To print this form, you will need to do so in sections)

Thank you.

* Required

Contact Information

1. First and last name: *

2. Name you would like to be called if different from above:

3. Full address (street address, city, state, zip code): *

4. Home phone number: *

5. Cell phone number: *

6. Work phone number: *

7. Email address: *

8. Preferred contact methods (check all that apply): *

- [ ] Email
- [ ] Cell phone (text)
- [ ] Cell phone (call)
- [ ] Home phone
- [ ] Work phone
- [ ] Other

Personal Information

9. Date of birth: *

10. Social Security number:

11. Driver's license number:

12. Marital status: *

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Widowed
- ◯ Separated
- ◯ Other

13. Significant other's full name (if you do not have one respond NONE or NA): *

14. Significant dates (e.g. anniversaries, loss of a loved one or pet, graduation, birth dates, etc.): *

15. Household Information (name, role (husband, wife, child, partner, etc.) and date of birth:
ie. Jane, child, 3/29/2010 *

Employment Information

16. Occupation: *

17. Employer name and how long have you worked for this employer? (If unemployed respond NONE or NA): *

18. If you are unemployed, please describe your current situation (If employed respond NONE or NA): *

Rating Scale of Concerns

19. Please describe your reasons for seeking counseling (including month/year the problem started): *

20. Have you ever experienced suicidal thoughts or harming self or others? Have you ever attempted suicide? If yes, please explain: *

21. Was there an event which made these issues or problems begin? If yes, please describe: *

22. Using a scale of 1-5, with 1 being lowest and 5 being highest, please rate your areas of concern. If you rate something over 4, please describe in more detail in the comment section below. *

	1 (none or minimal	2 (mild)	3 (moder
Mental health (general)	◯	◯	◯
Physical health (general)	◯	◯	◯
Addication	◯	◯	◯
Anger	◯	◯	◯
Anxiety	◯	◯	◯
Panic attacks	◯	◯	◯
Depression	◯	◯	◯
Mood swings	◯	◯	◯
Sleep issues	◯	◯	◯
Eating/diet/nutrition	◯	◯	◯
Work	◯	◯	◯
Finances	◯	◯	◯
Personal relationships	◯	◯	◯
Personal direction	◯	◯	◯
Spiritual	◯	◯	◯
Trauma/PTSD	◯	◯	◯
Memory problems	◯	◯	◯
Safety issues	◯	◯	◯

Major life change (birth, death, move, employment status)	◯	◯	◯

23. For each of the above items you rated 4 or higher please describe in more detail: *

Spiritual History

24. Briefly describe any religious or spiritual upbringing: *

25. Present religious or spiritual affiliation: *

26. Please describe why/why not this is an important part of your life?: *

27. Would you like your spiritual beliefs to be part of your therapy? If so, how? *

Medical & Psychiatric History

28. Describe your general health: *

29. Are you currently under a doctor's care?: *

- ◯ Yes
- ◯ No

30. If you answered "Yes" to the above question, please provide a brief description:

31. Primary care physician name and phone number: *

32. Psychiatrist name and phone number: *

33. Diagnosis: *

34. I give permission for Susan Hargett, LPC-S, NCC permission to contact: *

	Yes	No
Primary Care Physician	◯	◯
Psychiatrist	◯	◯

35. Please list all medications, including any over the counter medicines, vitamins, or supplements. Medication name, dosage, frequency, and for which condition you are taking it for: *

36. Have you ever been hospitalized for a physical illness or condition? If yes, please include date(s), reason(s) for hospitalization: *

37. Have you ever been hospitalized for a mental health illness or condition? If yes, please include date(s), reason(s) for hospitalization: *

38. Describe any medical or psychiatric conditions of your parents and/or siblings: ie. Mom, depression, thyroid issues *

39. Do you smoke or use vape products? If so, how often?: *

	Daily	Weekly	Monthly	Seasonal
Cigarettes	◯	◯	◯	◯
Vape products/e-cigarettes	◯	◯	◯	◯
Cigars	◯	◯	◯	◯
Tobacco pipe	◯	◯	◯	◯

40. Do you take drugs (illegal or those that are not prescribed to you)?: If so, how often *

	Daily	Weekly	Monthly	Seasonal
Narcotics (ie. fentanyl, heroin, morphine, opium, oxycodone)	◯	◯	◯	◯
Stimulants (ie. amphetamines, cocaine, khat, methamphetamine	◯	◯	◯	◯
Depressants (ie. barbiturates, benzodiazepines, GHB, rohypnol)	◯	◯	◯	◯
Hallucinogens (ie. ecstasy/MDMA, ketamine, LSD, peyote, mescaline, psilocybin)	◯	◯	◯	◯
Steroids (non-prescribed)	◯	◯	◯	◯
Marijuana/Cannabis (ie. marijuana concentrates, vaping)	◯	◯	◯	◯
Inhalants	◯	◯	◯	◯
Designer Drugs (ie. bath salts, K2/spice, synthetic opioids)	◯	◯	◯	◯
Other (ie. DXM, kratom, salvia divinorum)	◯	◯	◯	◯

41. Do you drink? If so, how often?: *

	Daily	Weekly	Monthly	Seasonal
Beer	◯	◯	◯	◯
Wine	◯	◯	◯	◯
Distilled liquor (ie. whiskey, gin, vodka, rum, tequila, brandy)	◯	◯	◯	◯
Sake	◯	◯	◯	◯
Liqueurs (ie. triple sec, amaretto, schnapps)	◯	◯	◯	◯

42. Any previous therapy/counseling? *

- ◯ Yes
- ◯ No

43. If you answered "Yes" to the above question, please describe when, where, how long, and what you worked on in therapy: *

44. What do you hope to achieve with therapy this time? (What are your therapy goals?): *

Personal Agreements

Providing your first, middle and last initial and your birth date serves that you have read and understand the information.

45. I understand that I may be asked to do certain "homework exercises" such as reading, praying, meditating, keeping a journal, exercising, changing unhelpful/unwanted behaviors, and otherwise acting in my own best interest. I understand that I am entirely responsible for my own actions, and I will always make my own final decision regarding counseling.

    I further understand that much of the work done will be to resolve issues and will depend on my honesty and willingness to do the things I need to do to move forward, even if it is painful and difficult.

    I understand that whatever I say in a session is strictly confidential and will not be released to anyone without my consent unless I am violating codes of abuse, harm to myself or others.

    I understand that I will pay in full for appointments not canceled with at least 24 hours notice. The rate is the full price of the scheduled session.

    As your therapist/counselor, you honor em by sharing your life and growth with me. I will not hide behind silence or position, and will have high regard for you as a person. I will bring the best that I know from my studies and experience. I will bring you the highest of my insight, wisdom, and spiritual guidance. I will keep a holistic and integrative perspective on our work together because I believe that the Physical, Spiritual, and Soul (mind-body, will, and emotions) all work together to form a whole healthy person.

    You can expect truth from me, even when you may not want to hear it. I will always have compassion and empathy for you in all that we do. I value you as a person in need of care. I will do my best to honor that.
    *

Authorization For Care of Records

Providing your first, middle and last initial and your birth date serves that you have read and understand the information.

46. In the event of the incapacitation or death of my counselor, I authorize the person my counselor has designated to handle my files/records to contact me and assist me in continuity of care, payment, and/or resolution files/records. *

Therapy Agreement

Providing your first, middle and last initial and your birth date serves that you have read and understand the information.

47. Service | Price

Service	Price
LPC-S 60 minute Intake (only one is required; 53+ minutes)	$150
LPC-S 60 minute follow up counseling session (53+ minutes)	$120
LPC-S 45 minute follow up counseling session (38-52 minutes)	$100
LPC-S 30 minute follow up counseling session (16-36 minutes)	$60
LPC-S 60 minute crisis counseling (30-74 minutes)	$140
Late cancellation (less than 24 hours)/No show	Full price of the scheduled session

Crisis call over five (5) minutes will be considered a telephone session and will be charged accordingly.

Soul Academy, PLLC accepts some insurance plans, please confirm whether or not you will use your insurance benefits by sending email to Susan@soulacademyus.com. Soul Academy, PLLC utilizes Headway or Alma to manage all insurance processing and billing. Co-pays are the client's responsibility, and as a result, the client is responsible for those charges and late cancellation/no show fees. If you change insurance carriers, it is your responsibility to update this information in your Headway or Alma client portal.

If you are a private pay client, you are responsible for all charges. If you are experiencing financial difficulty, please let me know.

Please log into your session a few minutes prior to our scheduled session time. If you are not logged in within 5 minutes after our start time I will send a reminder to you by text and/or email by your noted preference. If you still have not logged in within 15 minutes of our scheduled start time, without prior notice or arrangement, this is considered a no-show and the full session fee will be charged to the credit/debit card on file.

Please Note: I have a specific specialty that does **NOT** include the following services. Current criminal or civil court proceedings pending; Disability, FMLA or worker's comp evaluations; Court mandated treatment; Emotional Support Animal Evaluation/Letter; Active Substance Abuse/Addiction Treatment; Any long term, extensive issues/history of trauma from natural/man-made disasters, abuse, injury, illness, or other adverse events. I recommend that you look for a therapy that includes these as part of their work. I will provide referrals by request only.

Therapeutic approach/interventions: I use a variety of evidence based therapeutic techniques as well as holistic/integrative/complimentary and alternative medicine (CAM) including but not limited to: Yoga (poses, breathing, meditation/mindfulness), eco-therapy, humanistic, person-centered, solution focused, journal therapy, narrative therapy, positive psychology, strengths-based, bibliotherapy, and music therapy. *

Notice of Cancellation & No-show Policies

Providing your first, middle and last initial and birth date serves that you have read and understand the information.

48. I understand that situations arise in which you must cancel your appointment. Therefore, it is requested that you provide at least 24-hours notice to cancel or reschedule your appointment. This allows another person to schedule that appointment slot. Appointments which are cancelled or reschedule with less than 24 hours of notification are subject to a cancellation fee which is the full price of the scheduled session.

    Clients who do not show up for their appointments without a call to cancel are considered as a no-show and subject to a no-show fee which is the full price of the scheduled session. Any client who no-shows twice in a 12-month period are denied any future appointments unless no-show fees are paid in full. If a client cannot pay the fees, they are provided referrals to other agencies/therapists.

    *****If a client misses two consecutive scheduled session without a legitimate reason, the client will be considered to have given notice of termination of therapy. If you wish to resume services, we are creating a new arrangement and any new fees will apply.

    The cancellation, rescheduling, and no-show fees are the sole responsibility of the client and must be paid in full before the client's next appointment. If these fees are not paid in full within 24 hours of the next scheduled appointment, this appointment will be canceled by the therapist and a notification of the cancelled session will be sent to the client.

    Thank you. *

Required Credit/Debit Card Information

Providing your first, middle and last initial and birth date serves that you have read and understand the information.

49. Credit/debit card information is required to receive services.
    When you set up your client portal through Headway or Alma, whether you are using your insurance benefits or private pay, you understand you will provide your credit/debit card information before services are received. The card on file is charged for services, co-pays, and in the unlikely event there is a late cancel or no show this card is charged the full price of the session as indicated on the service fee portion of this document, unless we have made other arrangements.

    Please provide your first, middle, and last initial and your birth date below. *

Confidentiality & Notice of Privacy Practices

Providing your first, middle and last initial and your birth date serves that you have read and understand the information.

50. Counseling services as Soul Academy, PLLC are confidential. This means that, with rare exceptions, information shared in a counseling session is kept private and is not shared outside of the counseling relationship. The counselor will make exceptions to the confidentiality policy ONLY if a client is potentially self-destructive, harmful to others, or if a child or an elderly person is in danger. In these rare instances when confidentiality must be broken for the purpose of safety, every effort will be made to keep the client informed when private information must be shared with appropriate parties.

    Susan Hargett, LPC-S/Soul Academy, PLLC may occasionally consult another therapist to ensure the best possible care for each client.

    Clients may give the counselor written permission to speak with a specific person, such as a family member, friend, or doctor.

    Counseling records are the property of Susan Hargett, LPC-S/Soul Academy, PLLC. If a client needs access to their counseling records for any reason, a summary of the treatment history will be provided within 14 business days of written request (either mail or email). In addition, if the client is requesting treatment history to be shared with another therapist, consent for disclosure form must be completed by the client for reasonable information from the client records to be shared.

    The counselor is available to client via email and text only for general or logistical information. Although Susan Hargett, LPC-S/Soul Academy, PLLC uses a HIPAA-compliant email, email is NOT considered a secure, confidential method of communication, and because of this, email is not an appropriate venue to discuss complex issues. Clients may be referred to an office visit (telehealth) if electronic communication is of personal nature.

    Acknowledgement of Review of Notice of Privacy Practices: I have been given the opportunity to review the Notice of Privacy Practices (HIPAA), which explains how my personal health information will be used and disclosed. **If you did not receive a copy of the Notice of Privacy Practices HIPAA that is sent as an attachment to your email address, please contact me.** *

Consent, Benefits & Risks for Treatment

Providing your first, middle and last initial and your birth date serves that you have read and understand the information.

51. I authorize and request that Susan Hargett, LPC-S/Soul Academy, PLLC provide counseling, evaluation, treatment, and or assessment procedure, which now or during my care as a client as advisable. The frequency and type of treatment will be decided between my therapist and me.

    I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

    I understand that here is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur.

    I understand that the maximum benefit will occur with consistent attendance and that at times I may be conflicted about my therapy as the process can sometimes be uncomfortable.

    There are potential risks and benefits associated with counseling. Risks might include facing uncomfortable feelings, remembering unpleasant times in the past, or feeling the stress that can come with change in lifestyle and relationships.

    Benefits of counseling include improved coping skills, healthier relationships with friends and family, clear goals for the future, improvement in concentration and decision making, and feeling more in control in life.

    I have read and understand the confidentiality policy. I agree to treatment with Susan Hargett, LPC-S/Soul Academy, PLLC. *

Consent for Tele-mental Health

Providing your first, middle and last initial and your birth date serves that you have read and understand the information.

52. I understand that I am consenting to participate in tele-mental health with Susan Hargett, LPC-S/Soul Academy, PLLC as part of my psychotherapy. I understand that tele-mental health is the practice of delivering clinical health care services via technology-assisted media or other electronic means between a practitioner and a client who are located in two different locations.

    I understand the following with respect to tele-health:

    1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

    2) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

    3) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele-mental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

    4) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that tele-mental health services are not appropriate and a higher level of care is required.

    5) I understand that I am responsible for: a) providing the necessary computer, telecommunications equipment, and internet access for my teletherapy session, b0 ensuring security on my computer, and c) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

    6) I understand that during tele-mental health sessions, we could encounter technical difficulties resulting in service interruptions. If this occurs, the therapist will end and restart the session. If we are unable to reconnect within ten minutes please send a message to the message board through Betterhelp to discuss since we may have to re-schedule.

    7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

    I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have

been answered to my satisfaction. *

Emergency Protocols

Providing your first, middle and last initial and your birth date serves that you have read and understand the information.

53. I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

    In case of an emergency, my location is (if we typically meet outside of your residence please type in the address where we typically meet): *

54. My emergency contact person's full name, phone number, email, and full mailing address: *

Notice to the Public of Complaint Process

Providing your first, middle and last initial and your birth date serves that you have read and understand the information.

55. The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint. Please call 1-800-821-3205 for more information.

    Texas Behavioral Health Executive Council
    1801 Congress Ave., Ste. 7.300
    Austin, Texas 78701
    512-305-7700 *

Any Questions?

If you have any questions or concerns please direct them to Susan Hargett, LPC-S at susan@soulacade-myus.com.
