Malaina F. Hickey, LCSW
Licensed Clinical Social Worker

Client Information and Informed Consent for Services

Welcome and thank you for choosing Malaina F. Hickey, LCSW for your counseling services. Today's appointment will take approximately 50 minutes. I realize that beginning a process of counseling may be a major decision and you may have many questions. This document is intended to inform you of my policies, state and federal laws, and your rights. If you have any questions or concerns, please ask and I will try our best to give you all the information you need. When you sign this document, it will represent an agreement between you and I, Malaina F. Hickey, LCSW, and will provide consent for treatment.

Therapist
My name is Malaina F. Hickey, and I am licensed by the State of Texas to provide mental health services. I hold the following License: Licensed Clinical Social Worker (LCSW). I am in private practice and operate as an independent practitioner.

Mental Health Services
While it may not be easy to seek help from a mental health professional, it is hoped that through therapy you will change in the following ways: 1) gain greater insight into your situation and feelings, 2) develop expanded conceptualizations of your life, relationships, circumstances, and future; 3) move toward resolving your concerns; and 4) forge a life plan that promotes greater realization of your human potential, happiness, and success. As your therapist, using my knowledge of human behavior and human change process, I will make observations about your life situations and offer guidance as you seek new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you or I feel it would be helpful.

Sessions
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 of whether you feel comfortable working with the therapist you have chosen. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about the procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

Sessions last 50 minutes and normally an evaluation that will last for at least two sessions will be conducted. During this time, you and the therapist both decide whether your therapist is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy has begun, we will usually schedule one 50 minute session per week or according to your needs.

Professional Fees & Fee Agreement
Session Fee Schedule is as follows:

Initial Diagnostic & Evaluation Session (1st visit) – $150.00
Regular Office Visits (50 minutes) (Individuals, Couples & Play Therapy) - $ 120.00

The following is a fee agreement between you and Malaina F. Hickey, LCSW. You are expected to pay for each session in the amount of $_____ at the beginning of your session.

Insurance**:**
Fees and/or co-pays vary according to insurance companies. I authorize the release of any medical or other information necessary to process an insurance claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the undersigned counselor or physician.

Initials

Insurance company: _____ Group # _____
ID # _____ Insurance Provider phone number: _____
Policy Holder Name:_____ Employer: _____
Policy Holder DOB:_____ SS#_____

All fees (co-pays if using insurance) for counseling are due at the time services are rendered, payable by cash, check or credit card. Insufficient-funds checks will be returned upon full payment of the original amount plus $25.00.

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Confidentiality & Limitations

All communication with your counselor is confidential and will not, except under circumstances explained below, be disclosed to anyone outside of Counseling Services unless you give written authorization to release information.

A record is kept of your work with me. It contains information you have provided in writing as well as counseling notes of your sessions. The record remains in Counseling Services for a period of seven years following your last visit; at that time, it is destroyed. Your record never leaves the Counseling Center.

It is important that you understand that all identifying information about your therapeutic treatment is kept confidential. Information solicited by phone, written, or in person about clients will not be provided. You will need to sign consent to release information before any information is provided to a third party outside our office. This condition applies also in cases where coordination of treatment is necessary with another health professional (physician or psychiatrist). However, there are exceptions and/or limitations to confidentiality. The following are limitations to confidentiality:

- In cases of immediate risk/threat of suicide or homicide on the part of the client.
- In cases of child or elderly abuse or neglect **Initials**
- In cases required by law or court subpoena.

Emergency Situations

I am unable to provide 24 hour per day, seven days per week psychotherapy services. In the event that you become in need of emergency services when I am unavailable, you may contact the following for Emergency Services. Tarrant County: **Crisis Intervention – Fort Worth at (817)927-5544; John Peter Smith Hospital, Emergency Room at (817)927-1110.** Dallas County: **Dallas Suicide and Crisis Center at (214)828-1000; Parkland Psychiatric Clinic at (214)590-5536 or the Parkland Emergency Room at (214)590-8761.**

Cancellations

Cancellations must be received at least 24 hours before your scheduled appointment; otherwise you will be charged my full session fee of $120.00 for that missed appointment. You are responsible for calling to cancel or reschedule your appointment. The reason for this is that when you make an appointment you are reserving a time. As your therapist, I have agreed not to utilize that time slot for any other purpose. If you fail to keep your appointment and fail to give adequate notice, I am unable to schedule another use for that part of my workday.

I understand that my appointment reserves this time exclusively for me and if I don't cancel or re-schedule my appointment with at least 24 hour advance notice, I will be responsible for the full session fee of $120.00

Initials _____

APPOINMENT REMINDER NOTIFICATION:

Would you like to receive an appointment reminder 24 hours prior to your visit? ☐ YES ☐ NO

Do you prefer to be reminded via email? ☐ YES ☐ NO Email: _____

Do you prefer to be reminded via text? ☐ YES ☐ NO Cell phone number : _____

CONSENT TO TREATMENT:

By signing this Client Information and Consent Form as the client or Guardian of said client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

_____ _____

Signature – Client / Parent Date

_____ _____

Signature – Therapist Date

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Adult Personal Information

Name_____Date_____

Date of Birth _____/_____/_____ Age _____ Gender: ☐ Male ☐ Female

Address_____ Apt _____

City _____ State _____ Zip Code_____

E-mail _____OK to contact? ☐YES ☐NO

Home Phone _____ OK to contact? ☐ YES ☐ NO

Cell Phone _____ OK to contact? ☐ YES ☐ NO

Work Number _____ OK to contact? ☐ YES ☐ NO

Employer _____Occupation _____ Number of different jobs in past 3 years: _____ Last Grade / School Completed_____

Social Security #: _____-_____-_____

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

If married, separated, divorced, or widowed, how long: _____

Name of Spouse/Partner_____ Date of Birth ___/____/_____

Have Children: ☐ Yes ☐ No If yes, how many children? _____

Name of Children/Others in Household	Relationship	Date of Birth	Age	Lives with You?
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No

Physician Name _____ Date of last physical: ____/____/_____

Are you taking medication(s): ☐Yes ☐ No If yes, what type? _____

_____

Any health issues: _____

In Case of Emergency: I authorize Malaina F. Hickey, LCSW to contact _____

Relationship_____ Phone Number _____Alternate Number: _____

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ASSESMENT and HISTORY INFORMATION

This information will help you and your therapist begin to clarify your therapy goals.

Patient Name: _____ Date: _____

☐ Yes ☐ No Have you ever been treated by a psychiatrist?

☐ Yes ☐ No Have you ever been hospitalized for mental or chemical dependency treatment?

☐ Yes ☐ Have you ever been to counseling before? If yes, how long ago? _____

☐ Yes ☐ No Have you seen another therapist in the **past 24 months**?

If yes, who did you see? _____

☐ Yes ☐ No Have you ever attempted suicide?

If yes, when? _____

Briefly describe your reasons for seeking counseling services: _____

_____

What kind of things have you tried so far to handle this situation?: _____

_____

Please place a number that best corresponds to issues listed below that are currently issues or issues that have applied in the past - Mark a P for past i.e. if you had issues with drug use 10 years ago mark **Drug Use - P-10**: (rate only those that apply)

	RARELY		SOMETIMES			OFTEN		ALWAYS	
0-1	2	3	4	5	6	7	8	9	10

____Abuse – physical	____Abuse – sexual	____Abuse – emotional
____Abuse – neglect	____Aggression, violence	____Alcohol use
____Anger, hostility, irritable	____Anxiety, nervousness	____Attention, distraction
____Career concerns, goals, choices	____Co-dependence	____Confusion
____Compulsions	____Cruelty to animals	____Crying, sadness
____Custody of children	____Decision-making, indecision	____Delusions (false ideas)
____Depression	____Divorce, separation	____Drug Use (prescribed)
____Drug Use (illegal)	____Eating problems	____Financial
____Gambling	____Grieving	____Goals
____Guilt	____Headaches	____Impulsiveness
____Judgment	____Loss of control	____Marital/Partner
____Memory problems	____Menstrual, PMS, menopause	____Mood swings
____Obsession/compulsion	____Panic/Anxiety attacks	____Parenting
____PTSD	____School problems	____Self-esteem
____Sexual issues	____Sleep problems	____Stress
____Suicidal thoughts	____Tobacco use	____Temper/low tolerance
____Thought disorganization	____Work problems	

Other:_____

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In the past 36 months has there been a death of a family member or someone close to you?
☐Yes☐ No If yes, who? _____When: _____ Relationship: _____

Prior to the 36 months, has there been a death of someone that was close to you?
☐Yes☐ No If yes, who? _____ When: _____ Relationship: _____

Please rate below on a scale of 1 through 10, 1 = not at all, and a 10 = very much so:

_____ I was very close and had a good relationship with my father.

_____ I was very close and had a good relationship with my mother.

_____ I was very close and had a good relationship with my siblings.

_____ I have several good friends.

_____ I often have nightmares.

_____ I enjoy spending time alone.

_____ I have a tendency of agreeing with other people to avoid confrontations.

_____ I don't like being around other people, I want to be alone.

_____ I like myself.

_____ I have a healthy interest in sex.

_____ I sometimes am confused with my identity.

_____ I put the needs and wishes of others first before myself even if I am not comfortable with it.

_____ I think I am responsible for the way others feel and their behaviors

_____ I drink alcoholic beverages at least 3 times per week.

_____ I have a problem saying "no"

_____ Others can make me mad, frustrated, disappointed, or sad easily.

Fears or concerns of counseling: _____
_____

Goal or expectation of counseling: _____
_____

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Any Psychological Testing : _____

Number of previous marriages/partners _____

Religious Preference: Now: _____ In childhood: _____

Mother's Occupation _____ Her Age: _____ Age at Death: _____

Cause of Death: _____

Father's Occupation _____ His Age: _____ Age at Death: _____

Cause of Death: _____

How would you rate your parent's marriage/relationship? Very happy __ Happy __ Average __ Unhappy __

Were parents married? Yes ____ No ____ If divorced , what was your age when this occurred? _____

_____ _____
Client/Parent/Guardian Date

As witnessed by:

_____ _____
Malaina F. Hickey, LCSW Date
Therapist

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Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient/Client: _____

Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices for Malaina F. Hickey, LCSW. I understand that if I have any questions regarding the notice or my privacy rights, I can contact Malaina F. Hickey, LCSW.

_____

Signature of Patient/Client **Date**

_____

Signature of Parent, Guardian or Personal Representative* **Date**

_____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ **Patient/Client Refuses to Acknowledge receipt:**

_____

Signature of Staff Member **Date**