

SA Counseling, PLLC
2621 N. Main Ave.
San Antonio, TX 78212
james@sacounselingpllc.com
210-239-2726

Intake Form

Name:

Date of Birth:

Address:

Email:

Phone Number:
c:

Emergency Contact Person:

Occupation:

Emergency Contact Phone #:

Employment Address:

Marital Status & Living Situation:

Partner/Spouse Name:

What brings you in to counseling today, how long has the problem(s) been going on and what have you tried to address the situation?

Any medical conditions or diagnoses?

Please list all medications taking with dosage and frequency along with any supplements you take:

Prior therapy or psychological diagnosis?

Military Service: Y N

Any psychiatric hospitalizations?

Any incarceration or legal problems:

Highest level of education:

Substance use past and present (alcohol & tobacco included):

Amount & Frequency:

Alcohol Use History

- Have you ever tried to cut back on your alcohol use? Yes No
- Have people ever annoyed you by criticizing your drinking? Yes No
- Have you ever felt guilty about your alcohol abuse? Yes No
- Have you ever used alcohol as an "eye opener" in the morning? Yes No
- Have you ever missed work due to alcohol use? Yes No

Children

| Name | Living or Deceased <i>(please circle one)</i> | | Age | Gender | Strength of relationship <i>(please circle one)</i> | | | | | | | | | | | |
|------|--|----------|-----|--------|--|---|---|---|---|---|---|---|---|---|----|------------|
| | Living | Deceased | | | Not close | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very close |
| | Living | Deceased | | | Not close | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very close |
| | Living | Deceased | | | Not close | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very close |
| | Living | Deceased | | | Not close | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very close |

Do you have a social support network, that is friends and family you can call for help?

How would you describe current family?

How would you describe your family of origin?

Any psychological diagnosis in your family of origin? If so, what and whom?

Any trauma in your past? If so, when and how frequent?

Mental, physical or sexual abuse in past? If so, when and how frequent?

Are you seeing things or hearing things that are not there?

Do you have long periods with large amounts of energy in which you can stay up for days at a time and work?

Do you ever learn you did something you do not recall doing? Or do you ever realize you are somewhere and don't recall how you got there and what you are doing; said differently, do you ever lose periods of time in your life?

Are you currently having suicidal thoughts?

Past suicidal or homicidal attempts? If any, please list number of attempts and approximate dates.

Do you harm yourself in any way? If so, when was the last time and please explain what you did.

If client is a minor, has there been a change in school performance?

What do you do for fun?

Please describe your diet:

Religious affiliation or spirituality if any:

How often do you exercise?

What are your goals for counseling?

Is there anything else you think I should know?

Patient Health Questionnaire-9 (PHQ-9)

| Over the last 2 weeks , how often have you been bothered by the following problems? <i>(please circle one number below to indicate your answer)</i> | Not at all | Several days | Over half the days | Nearly every day |
|---|------------|--------------|--------------------|------------------|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

Add the score for each column: + + +

Total Score (add your column scores) =

If you checked off **any** problems, how **difficult** have these made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
 Somewhat difficult
 Very difficult
 Extremely difficult

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Generalized Anxiety Disorder 7-Item (GAD-7) Scale

| Over the last 2 weeks , how often have you been bothered by the following problems? <i>(please circle one number below to indicate your answer)</i> | Not at all | Several days | Over half the days | Nearly every day |
|---|------------|--------------|--------------------|------------------|
| 1. Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it's hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

Add the score for each column: + + +

Total Score (add your column scores) =

If you checked off **any** problems, how **difficult** have these made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
 Somewhat difficult
 Very difficult
 Extremely difficult

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Intern Med. 2006; 166; 1092-1097.

Counseling Agreement & Informed Consent

Please read and sign the following prior to seeing your counselor

CONFIDENTIALITY

Confidentiality means that therapists have a responsibility to safeguard information obtained during treatment. It is important that you understand that all identifying information about your assessment and treatment is kept confidential, except as noted below. In order to protect your confidentiality, you must sign a release of information before any information about you is provided to a third party. SA Counseling, PLLC does not accept insurance. Health insurance companies and managed care companies often require information regarding diagnosis, symptoms, treatment goals, and prognosis about the insured before reimbursement is considered. Such companies may also request a copy of your records. SA Counseling, PLLC has chosen not to take insurance for these and other reasons. It is important that you understand that the laws of the State of Texas allow exceptions to confidentiality. In certain situations, mental health professionals are required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, in these situations SA Counseling, PLLC is not required to inform you of our actions. This includes the following:

- Confidentiality does not apply to cases of suspected abuse/neglect of children or the elderly as well as someone who cannot take care of themselves.
- Confidentiality does not apply to cases of potential harm to self or others.
- A mental health professional may disclose confidential information in proceedings brought by a client against a professional.
- Confidentiality does not apply to cases involving criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
- Confidentiality may not apply in cases involving legal proceedings affecting the parent-child relationship.
- Confidentiality may not apply to cases involving a minor child. In such cases, the mental health professional may advise a parent, managing conservator, or guardian of a minor, with or without minor's consent, of the treatment needed by or given to the minor.

HEALTH INFORMATION PRIVACY POLICY SUMMARY

The following is a summary of how your protected health information is used and disclosed and how you can obtain access to this information.

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you and/or your child receive. We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each counseling room. You may request a copy of our notice at any time.

We currently use TherapyNotes software to maintain electronic health records for all clinical services provided by SA Counseling, PLLC. The software we are using for your electronic health record is 100% HIPAA compliant, meeting and exceeding government security standards for data transmission and storage. TherapyNotes maintains with the highest security standards. Only your provider and the clinical director have access to your records stored electronically. Although there are limits to confidentiality with electronic health records (e.g., loss of information, unauthorized access of information), we believe that the safety features provided by TherapyNotes appropriately address these concerns.

Your Rights as a Client of SA Counseling, PLLC

Although your health record is the physical property of SA Counseling, PLLC, the information contained in your health record belongs to you with the exception of psychological test results. You have the right to:

- request a restriction on certain uses and disclosures of your and/or your child's information
- obtain a paper copy of the notice of privacy practices upon request
- inspect and obtain a copy of your and/or your child's health record
- amend your and/or your child's health record as provided by regulation
- obtain an accounting of disclosures of your and/or your child's health information as provided by law
- request communications of your and/or your child's health care information by alternative means or locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Complaint Regarding the Privacy of Your Health Information

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact our privacy officer. You also may send a written complaint to the U.S. Department of Health and Human Services.

Our Legal Duty Regarding the Privacy of Your Health Information

We are required by law to protect the privacy of your health information, provide this notice about our privacy policy, and follow the information practices that are described in this notice. If you have any questions or complaints, please contact James Anderson, 2621 N. Main Ave, 210-239-2726, james@sacounselingpllc.com.

Filing a Complaint Against Your Therapist

If you wish to file a complaint against your therapist, you can do so by contacting the Texas Behavioral Health Executive Council, George H.W. Bush State Office Building, 1801 Congress Ave., Ste. 7.300, Austin, Texas 78701, Main Line (512) 305-7700, Investigations/Complaints 24-hour, toll-free system (800)

821-3205. 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.

THE BENEFITS OF COUNSELING

One major benefit that may be gained from participating in counseling is the resolution of the concerns brought to therapy. Other possible benefits may be a better ability to cope with marital, family and other interpersonal relationships, and /or a greater understanding of personal goals and values.

THE RISKS OF COUNSELING

To allow you to make informed decisions about your counseling, SA Counseling, PLLC wishes to make you aware of certain risks involved in counseling. You may experience discomfort, such as anger, depression, or frustration during therapy as you remember and therapeutically resolve unpleasant events. Seeking to resolve concerns between family members, marital partners, and other persons can similarly lead to discomfort as well as relationship changes that may not be originally intended. The greatest risk of counseling is that it may not by itself resolve your concerns. We do our best to assess progress and provide referral to other sources if that is deemed necessary and appropriate.

COST OF SERVICE

The cost of service for therapy is **\$150** for a 50-minute session with a licensed professional counselor. Should the fee present an unusual hardship, you may speak with your counselor about this during your initial visit. Insurance is not accepted. Clients will be provided a receipt if requested in which they can use to file with their insurance company for reimbursement. SA Counseling, PLLC does not participate in Medicare; thus, clients are fully responsible for the cost of all services and may not submit a superbill for reimbursement from Medicare.

PAYMENT OF FEES

All services rendered are the financial responsibility of the client or the client’s parent or guardian. All fees for counseling are to be paid when the service is rendered. You will pay your fee to your counselor. If the client is in arrears, he/she will not be seen again in therapy until the respective balance is paid in full. We accept cash and personal check.

CANCELLATIONS

Cancellations must be made twenty-four hours in advance to avoid a charge of **\$50.00**. Missed appointments will be charged at the regular fee.

NSF CHECKS AND REJECTED CREDIT CARD CHARGES

There will be a **\$25.00** charge for each NSF check or “do not honor” credit card payment.

Any recording of counseling sessions are not permitted. Doing so will result in termination of counseling services offered by SA Counseling, PLLC.

Written Acknowledgement and Consent to Counseling

I have reviewed this Counseling Agreement & Informed Consent, including the summary of SA Counseling, PLLC Privacy Policy. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

I accept this agreement and herewith consent to counseling at SA Counseling, PLLC.

Client Name (Please Print)

Client or Legal Representative Signature

Printed Name

Date

Client or Legal Representative Signature

Printed Name

Date

Counselor Signature

Printed Name

Date

Miscellaneous Charges

Should you need any of the following services, the costs are listed.
Please review to become aware and initial (below).

| Service | Charge | Date of Service |
|---|---------|-----------------|
| Professional Letter to include if client submits for reimbursement from insurance company and therapist is required to complete requested paperwork for client's reimbursement. | \$75.00 | |
| Official Paperwork | \$50 | |
| Telephone Consultation 0-15 minutes | \$25 | |
| Telephone Consultation 16-30 minutes | \$50 | |
| | | |
| | | |

| Fees related to legal matters | Charge | Date of Service |
|-----------------------------------|----------|-----------------|
| Letters to attorneys | \$50.00 | |
| Review of records | \$150/hr | |
| Court Appearances (portal-portal) | \$250/hr | |
| Depositions (portal-portal) | \$250/hr | |
| On-call for testimony | \$150/hr | |
| Cancellation | \$150/hr | |

_____ Initial

Consent for Counseling of a Minor (under 18 years of age)

The following statements provide your legal consent to and financial responsibility for counseling services to a minor. These statements are important to protect the child, the parent/guardian/conservator, and the therapist(s). Please carefully review this information and sign where indicated. You are encouraged to discuss with your therapist any questions you may have concerning this form.

Statement of Responsibility and Grant of Permission for Counseling:

I am the Parent Legal Guardian Managing Conservator of (/ /)
check one of the above *Name of Minor* *Date of Birth*

I am legally responsible for the child named above and grant permission to SA Counseling, PLLC to conduct counseling with this child. Upon request, I will provide any necessary documentation.

I accept responsibility for the timely payment of all fees due to SA Counseling, PLLC for services provided to this child.

Signature:

Date:

Duty to Warn Notice

SA Counseling, PLLC is committed to confidentiality and privileged communication with all clients. There are, however, several exceptions. According to Texas law, any evidence of child abuse must be reported to the authorities. If any individual intends to take harmful, dangerous or criminal action against another individual, or against himself/herself, it may be the counselor's duty to report such action or intent.

I acknowledge that I have read or heard read the above Duty to Warn Notice and understand the counselor's responsibility to take action where necessary.

Signature:

Date: