Harmony J. Moses, MA LPC
3600 Shire Blvd Suite 208
Richardson, TX 75082
214.998.0111

# New Client Intake/Biographical Information:

Name: Date of Birth: Age:

Address: City/State/Zip

Cell Phone: Home: Work:

You would be preferred to be contacted at: _____home _____cell _____work

Email address:

Occupation: Education:

Employer: Address:

Marital Status:

_____Single _____Engaged _____Married _____Separated _____Divorced _____Widowed

Significant Others Name: Age: Phone Contact:

Occupation: Employer:

Name and Ages of Children:

Number of Marriages and Length of each:

Emergency Contact Name and Phone:

Name of Physician and/or Psychiatrist: Phone:

Address:

Current Place of Worship: Location:

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Who suggested or referred you to counseling? (Check all that Apply)

_____Self_____Parent_____Friend_____Empolyer_____Physician_____Other_____

_____

Did you find my services via the internet? Which search engine did you use?

_____

Please list all medications you are currently taking: List of recreational drug use:

_____

List previous mental/psychological diagnosis:

_____

Circle all of the following that apply to you currently or in the past:

I have experienced or am experiencing:

*Extreme sadness or depression *Anxiety or constant worry *ADHD

*Severe mood swings *Inability to control my behavior or feelings *Drug/Alcohol abuse

*I drink alcohol most days of the week or everyday *I am abusive in my relationships *Poor decision making

*I am or have been abused (physically, emotionally or sexually) *Trauma *PTSD *Infidelity

*Trouble with the law or authority *Sleep disturbances *Intimacy *Divorce

*Loss of a loved one * Trouble 'fitting in' *Lack of self-esteem *Struggling with my spirituality

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Client Rights and Responsibilities (3Pages):

Welcome to therapy! In an effort to help you make informed decisions about your therapy, I would like to tell you about my background and qualifications as a therapist and about your rights and responsibilities.

**EDUCATION:**

Master of Arts in Counseling, Argosy University, Dallas, Texas
Bachelor of Arts in Psychology, University of Texas Dallas, Brain and Behavioral Science, Dallas Texas

**METHOD OF TREATMENT:**

My method of treatment combines a holistic approach of both family systems therapy and psychodynamic therapy. This combination gives us the ability for deep unpacking and understanding of struggles that can be complicated and deeply rooted. This means that I look at most issues in the context of both family background and environment, and deeper dynamics of your traits, both learned and innate personality, and try to help you understand your thoughts, feelings and actions within your current dynamics. I take a positive approach to problems, believing that people are resilient and have tremendous abilities to address their life situations. It is my role as a therapist to help you understand the dynamics of your situation, how you got there, and to help you use your personal strengths to address your issues for desired growth.

**GOALS, RISKS, AND BENEFITS:**

There is always a risk of psychological side effects from psychotherapy. Sometimes symptoms worsen before they get better. Often therapy brings up painful emotions. Our goal is to confront issues and emotions together, and with time, to work through them. Other types of therapy, such as support groups or therapy groups, may also be appropriate in your situation.

**LENGTH OF TREATMENT:**

Length of treatment is very difficult to predict. Each individual has unique strengths and weaknesses, and each problem is different from the next. It is my goal that each client will finish therapy in a timely manner, without unnecessary waste of time or money.

**FEES:**

Our sessions will be 60 minutes long, we will end on time as a respect to both of our schedules, unless more time is available and agreed upon. Together we will decide how often you should come, therapy is a process and each client has different needs and issues. Each session costs

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$150 per 60 min; $225 per 90 min. In many cases, insurance will reimburse you for all or part of this fee. I do not file insurance claims for you. You must do this on your own. However, I will provide you with the appropriate documentation for you to give your insurance company. I ask that you pay in full at each session. You will be billed for missed sessions unless you call 24 hours in advance to cancel the appointment. (See document Guarantee of Payment) Exceptions will be made, of course in emergency situations.

By signing this agreement you authorize me to bill the following credit card provided on the "Guarantee of Payment Form" for outstanding balances.

If you the client requests, or the courts request or subpoena testimonial for any reason from me the provider, all costs of $300 per hour will be your responsibility and paid to provider, Harmony J. Moses MA, LPC for length of time spent going to and from court and during court sessions, due upon receipt. A retainer will also be requested if deemed appropriate by the provider.

**OUR RELATIONSHIP:**

Although you will be sharing personal things during the course of therapy, the tie between us is professional rather than personal. It is important to keep this relationship clear, so spending time with you socially, accepting phone calls from you at my home, or being friends on social media is inappropriate.

Sexual intimacy between a therapist and a client is always inappropriate and illegal. If this has happened to you in the past, you should file a complaint with the appropriate licensing agency.

**YOUR RIGHT TO PRIVACY:**

I will not share the things you tell me without written permission from you. However, I can be forced to reveal our communications if:

- I suspect child or elder abuse.
- I feel that there is a threat that you will harm yourself or others.
- You become unable to take care of yourself and additional help is needed.
- There is a licensure board inquiry
- Legal matters are involved.

It is important in the field of psychotherapy to consult with other professionals about difficult cases. Therefore, it is possible that I will discuss your case with other therapists for the purpose of gaining information or insight about your situation. If this occurs, your name will not be revealed during these discussions. Your insurance company will sometimes contact me about the progress of treatment. The release form you sign at the outset of treatment allows me to discuss your case with them. I will respect your privacy within these limitations.

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**EMERGENCIES:**

During office hours, you can reach me at 214.998.0111. In the event of a genuine emergency, you can contact me at 972.998.4852. If for some reason you cannot reach me, contact your physician, your local emergency room or the local police department when necessary and appropriate. It is your responsibility to seek the appropriate resources in emergency situations.

If you have any questions regarding your therapy, please feel free to ask.

I have read the preceding information and understand my rights and responsibilities as a client.

_____ _____

Client signature Date

_____ _____

Therapist signature

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## CANCELLATION AND RESCHEDULING POLICIES

Harmony J. Moses, MA LPC maintains a strict 24-hour cancellation policy. I ask that you respect this policy and give a full 24-hours notice if you need to cancel or reschedule. All clients will be asked to commit to this policy when scheduling a session, new clients are on a waiting list, so please respect my time and the opportunity for other clients to get on my schedule. Your credit card will be charged in the event of a no-show or last-minute cancellation.

## GUARANTEE OF PAYMENT

I _____, hereby authorize Harmony J. Moses, MA LPC to charge the credit card provided for late cancellations and reschedules. I am aware of the $5 charge to run the card added to my standing session fee of $150 per 60 min, $225 per 90 min session, etc. I acknowledge that I'm fully responsible for paying the total amount of the originally scheduled time.

_____

Name of card holder: Card Number:

_____

Exp date: V-code:

_____

Billing address:

_____

Client Signature Date

_____

Therapist Signature Date