Davis Art Therapy and Counseling Intake

2007 N. Collins Blvd. #411, Richardson, TX 75080
Phone: (972) 544-6633

This intake packet applies to services provided by Davis Art Therapy and Counseling, LLC, a Texas professional counseling practice. Dallas Art Therapy is a separate 501(c)(3) nonprofit organization.

This intake packet is provided for client information and informed consent. It is not legal advice.

Consumer Notice: Your Rights Under Texas Health and Safety Code §181.105 | HB 4224 This notice is provided in compliance with Texas law and does not replace the Notice of Privacy Practices.

You have the right to request access to your health care records maintained by this practice.

To request your records: - Contact our office at: (972) 544-6633 - Submit your request by email or mail: - Email: info@dallasarttherapy.org - Mail: 2007 N. Collins Blvd. #411, Richardson, TX 75080 - A written records request or authorization form is required.

If you have questions about the records request process, please contact our office.

How to contact the licensing authority

This practice is regulated by the **Behavioral Health Executive Council (BHEC)**.

Behavioral Health Executive Council (BHEC) - Website: https://bhec.texas.gov/contact-us/ - Phone: (512) 305-7700

BHEC provides consumer assistance and accepts complaints related to professional conduct and licensure.

File a consumer complaint

If you wish to file a consumer complaint regarding access to health care records or other consumer concerns, you may contact:

Texas Office of the Attorney General
Consumer Protection Division

Online Complaint Portal:
https://www.texasattorneygeneral.gov/consumer-protection/file-consumer-complaint

Questions about this notice?

For questions related to House Bill 4224 or posting requirements, contact: - HCR_PRU@hhs.texas.gov

1) Client Intake Information

Client name: _____
Preferred name (if different): _____
Date of first appointment: ____/____/_____
Date of birth: ____/____/_____ Age: _____
Gender: _____ Pronouns: _____

Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) _____-_____
Client email: _____

(If Applicable): Parent / Legal Guardian Information

Parent / Legal Guardian 1 (Primary contact):
Name: _____
Relationship to client: _____
Phone: (__***) -***
Email: _____

Parent / Legal Guardian 2 (if applicable):
Name: _____
Relationship to client: _____
Phone: (__***) -***
Email: _____

Persons also residing in the home (optional):

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

☐ Parents are married
☐ Parents are divorced or separated
☐ Other custody arrangement: _____

If parents are divorced or separated, a **current court order** outlining legal decision-making authority and access to mental health records **must be provided** prior to or at the first appointment.

2) Communication Consent and Limits Please initial your choices.

Secure portal messaging (TheraNest EHR (by Ensora)) is strongly preferred for any communication that includes protected health information (PHI). Standard email may be used for scheduling or administrative purposes only.

A) Email (scheduling only)

- _____ I consent to receive scheduling or administrative communication by email. I understand email is not fully secure.
- _____ I do not consent to email communication.

B) Telephone messages

- _____ I consent to voicemail or phone messages that may include limited PHI.
- _____ I do not consent to voicemail or phone messages.

C) Text messaging (scheduling only)

- _____ I consent to text messages for scheduling and limited administrative communication only. I understand texting is not fully secure.
- _____ I do not consent to text messaging.

Response time and emergencies

- Routine messages may be returned within up to **two business days**.
- Messages received outside of business hours, on weekends, or holidays will be addressed on the next business day unless otherwise stated.
- **Do not use email, text, or secure portal messaging to report suicidal intent or urgent safety concerns.** If you are in immediate danger, call **911** or go to the nearest emergency room.
- You may also call or text **988** (Suicide and Crisis Lifeline, 24/7).

3) Treatment History

Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere?
( ) Yes ( ) No

Have you had previous counseling or psychotherapy?
( ) Yes, with: _____
( ) No

Are you currently taking prescribed mental health medication?
( ) Yes ( ) No
If yes, list: _____
Prescribed by: _____

Vitamins or supplements (optional): _____

4) Health and Social Information

Do you currently have a primary physician? ( ) Yes ( ) No
If yes, who: _____

Are you currently seeing more than one medical specialist? ( ) Yes ( ) No
If yes, list: _____

When was your last physical? _____

Persistent physical symptoms or health concerns (optional):
_____

Medication for physical health concerns (optional):
_____

Sleep concerns? ( ) Yes ( ) No
If yes: ( ) too little ( ) too much ( ) poor quality ( ) disturbing dreams ( ) other: _____

Exercise: times per week _____ Duration each time _____

Appetite or eating concerns? ( ) Yes ( ) No
If yes: ( ) eating less ( ) eating more ( ) bingeing ( ) restricting

Significant weight change in the last 2 months? ( ) Yes ( ) No

Alcohol use? ( ) Yes ( ) No
In a month, 4 or more drinks in a 24-hour period? ( ) Yes ( ) No

Recreational drug use frequency: ( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

Tobacco use? ( ) Yes ( ) No

Romantic relationship? ( ) Yes ( ) No
If yes, length: _____ Relationship quality 1-10: _____

Significant life changes or stressors in the last year? ( ) Yes ( ) No
If yes, explain: _____

5) Symptom Checklist and Safety Screening (Optional)

This checklist is a screening tool only and does not constitute a diagnosis. Responses help your therapist understand areas that may need further assessment.

Please indicate Yes or No.

Symptom	**Yes**	**No**
Extreme depressed mood	( )	( )
Dramatic mood swings	( )	( )
Rapid speech	( )	( )
Extreme anxiety	( )	( )
Panic attacks	( )	( )
Phobias	( )	( )
Sleep disturbances	( )	( )
Hallucinations	( )	( )

Symptom	**Yes**	**No**
Unexplained losses of time	( )	( )
Unexplained memory lapses	( )	( )
Alcohol or substance abuse	( )	( )
Frequent body complaints	( )	( )
Eating disorder	( )	( )
Body image problems	( )	( )
Repetitive thoughts (obsessions)	( )	( )
Repetitive behaviors (checking, hand washing)	( )	( )

Notes (optional): _____

Safety screening

Suicidal thoughts in the past two weeks? ( ) frequently ( ) sometimes ( ) rarely ( ) never
In the past? ( ) frequently ( ) sometimes ( ) rarely ( ) never
History of suicide attempts? ( ) yes ( ) no If yes, when: _____

Endorsing suicidal thoughts does not automatically require hospitalization; responses are used to support appropriate clinical care and safety planning.

6) Occupational and Spiritual Information (Optional)

Currently employed? ( ) Yes ( ) No
Employer or position: _____

Work-related stressors (optional): _____

Education or school (optional): - Name of school: _____ - Current grade or level (optional): _____

Spiritual or religious? ( ) Yes ( ) No
If yes, faith (optional): _____

7) Family Mental Health History (Optional)

Has anyone in your family experienced difficulties with the following? If yes, list family member.

Difficulty	Yes	No	Family member(s)
Depression	( )	( )	_____
Bipolar disorder	( )	( )	_____
Anxiety disorder	( )	( )	_____
Panic attacks	( )	( )	_____
Schizophrenia	( )	( )	_____
Alcohol or substance abuse	( )	( )	_____
Eating disorders	( )	( )	_____
Learning disabilities	( )	( )	_____
Trauma history	( )	( )	_____
Suicide attempts	( )	( )	_____
Chronic illness	( )	( )	_____
Other	( )	( )	_____

8) Strengths, Preferences, and Goals

Strengths (optional): _____

What do you like most about yourself? (optional): _____

Effective coping strategies you have learned (optional): _____

Color blind? ( ) Yes ( ) No
Allergies (optional): ( ) wheat ( ) gluten ( ) dairy ( ) nuts ( ) other: _____

Goals for therapy:

1. _____

2. _____

3. _____

9) Appointments and Attendance Policy

Your therapy time is reserved for you.

- If you cancel or reschedule with less than **24 hours** notice, you will be charged a **$100** late cancellation fee.
- Late cancellation and no-show fees are administrative fees and are not covered by insurance.
- **Late cancellation exception only:** The late cancellation fee may be waived if the appointment is rescheduled and completed within the **same calendar week**, based on availability. Availability is not guaranteed.
- No-show appointments will be charged a **$100** fee. No-show fees are not waived by rescheduling.
- **Telehealth option:** If you anticipate you will not be able to arrive on time, please contact us as soon as possible. When clinically appropriate and scheduling allows, we may be able to convert an in-person session to telehealth.
- **Attendance issues and scheduling limits:** An “attendance issue” means a late cancellation (less than 24 hours’ notice) and/or a no-show. After **two attendance issues** within a **six-month period**, scheduling needs will be discussed with the therapist, as permitted by applicable law. This policy is applied consistently.
- If you arrive late, the session will still end at the scheduled time.
- Repeated late cancellations or no-shows may lead to termination of care.
- If you have not had an appointment for **60 days**, you may be discharged from care.

10) Confidentiality

Therapy is confidential. No information is released without your written consent unless required or permitted by law.

Limits of Confidentiality

Examples of situations where disclosure may be required or permitted include (not an exhaustive list): - Suspected abuse or neglect of a child, elderly person, or disabled person - Threats of serious harm to self or others - Court orders or other legal requirements - Certain legal proceedings where mental health may be at issue - Professional consultation, supervision, or quality assurance (minimum necessary information) - Billing, payment, and healthcare operations

If disclosure is compelled by law, you may be responsible for costs involved in producing records and the therapist’s hourly rate for time spent responding, including record review, travel, and testimony.

If you have questions about confidentiality, please discuss them with your therapist.

11) Emergency Information

This practice does not provide 24-hour crisis services.

If immediate treatment is needed, call **911**, go to the closest emergency room, or the hospital covered by your insurance.

988 Suicide and Crisis Lifeline (24/7)

12) Emergency Contact

Emergency contact name: _____
Relationship: _____
Phone: (_____) _____-_____

13) Payment Policy and Insurance Information

Primary insurance

Insurance carrier: _____
ID#: _____
Subscriber name: _____
Subscriber DOB: ____/____/_____
Provider hotline: (_____) _____-_____

Co-pay per session: $_____ Deductible per year: $_____
Deductible has been met this year? ( ) Yes ( ) No

Secondary insurance (if applicable)

Insurance carrier: _____
ID#: _____
Subscriber name: _____
Subscriber DOB: ____/____/_____
Provider hotline: (_____) _____-_____

Co-pay per session: $_____ Deductible per year: $_____
Deductible has been met this year? ( ) Yes ( ) No

Fees

Provider type	Session fee (53+ minutes)
Fully licensed clinician	$200
LPC Associate	$100
MA practicum intern	$60

Payment is due at time of service unless otherwise arranged.

14) Telehealth Informed Consent

Telehealth involves providing therapy services using secure audio and/or video technology. Telehealth may not be appropriate for every concern or every session.

- I understand there are potential risks to privacy and confidentiality with electronic communication, even when secure platforms are used.
- I agree to participate from a private location and to use a secure internet connection when possible.
- I understand technology problems may interrupt a session. If we are disconnected, the therapist will attempt to reconnect. If reconnection is not possible, the therapist may contact me by phone to complete the session or reschedule.
- I understand telehealth is not appropriate for emergencies. If I am in immediate danger, I will call 911 or go to the nearest emergency room. I may also call or text 988.
- I agree to provide my physical location at the start of each telehealth session.
- I understand telehealth services are provided only to clients physically located in the state of Texas at the time of the session.

Telehealth consent (adults, age 18+)

_____ I consent to receive therapy services via telehealth when clinically appropriate.

Telehealth consent (clients under 18)

Parent/guardian name (printed): _____
Relationship to client: _____

_____ As the parent/legal guardian, I consent for the minor client to receive therapy services via telehealth when clinically appropriate.

15) Informed Consent for Treatment

Davis Art Therapy and Counseling offers individual and group art therapy and counseling to children, adolescents, and adults.

Participation in therapy is voluntary, and I may withdraw consent at any time.

I understand: - Therapy involves benefits and risks. I may discuss questions about treatment at any time. - I am responsible for understanding my insurance coverage, including co-pays and deductibles. - Fees not paid by insurance are my responsibility. - Late cancellation and no-show fees are not typically covered by insurance.

Concerns and complaints

If you have a concern about services, please contact our office at **(972) 544-6633** or use **secure portal messaging** within **TheraNest EHR (by Ensora)** so we can try to address it promptly.

I understand I have the right to make a complaint and receive a fair response in a reasonable amount of time.

16) Authorizations and Acknowledgments

A) Release of Information (Authorization)

Client name: _____
DOB: ____/____/_____ Client ID (if applicable): _____

I, _____, authorize reciprocal disclosure between my therapist and:

Name or organization: _____
Contact information: _____

Information authorized (check all that apply): - ( ) My personal records - ( ) Photography of artwork made in art therapy - ( ) Photography of artwork for training or consultation (de-identified) - ( ) Coordination of care with other providers (minimum necessary) - ( ) Supervision purposes - ( ) Other:
_____

Artwork will not be used for marketing or public display without a separate, specific written authorization.

I understand I may revoke this consent in writing at any time, except to the extent action has already been taken in reliance on it.

This authorization expires (choose one): - ( ) 60 days after discharge - ( ) On this date: ____/____/_____ - ( ) On this event or condition:
_____

B) Notice of Privacy Practices (Acknowledgment)

I acknowledge that I have received and understand the Notice of Privacy Practices and my rights concerning use and disclosure of protected health information.

Clinical records are retained in accordance with Texas law: a minimum of seven (7) years for adults and seven (7) years after a minor reaches age 18.

17) Social Media and Technology Policy

Friending and following

- The therapist does not accept friend or contact requests from current or former clients on social media (for example, Facebook or LinkedIn). This helps protect privacy and confidentiality and preserves the therapeutic relationship.
- Clients are welcome to view and share content from the public Facebook page for Dallas Art Therapy. The therapist does not friend or follow clients via a personal account.

Interacting and confidentiality

- Please avoid using social media direct messages or public posts to communicate with the therapist. These channels are not secure and may not be read in a timely manner.
- Do not use public posts (tagging, posting on a wall) to communicate, as this may compromise confidentiality.
- If you need to contact the therapist between sessions, you may call or text **(972) 544-6633**, or use **secure portal messaging** within **TheraNest EHR (by Ensora)**.

Email communication

- Standard email is not completely secure.
- All email exchanges (including those through **TheraNest EHR (by Ensora) secure portal messaging**) may become part of your legal record.

Documentation and record keeping

- The practice uses **TheraNest EHR (by Ensora)**, a HIPAA-compliant, secure EHR practice management service, to store clinical files, therapy notes, billing records, and related documentation.
- The practice may utilize HIPAA-compliant AI to assist in creating or managing therapy notes. AI is used only for secure note management or generation of typed summaries, not for clinical decision-making or diagnosing. Notes remain confidential and are stored securely.
- In the event of the therapist's death or incapacity, arrangements have been made for another licensed mental health professional (or designated custodian) to manage or dispose of client records in accordance with professional standards and state regulations.

Business review sites

- If you have concerns about services, please reach out directly by phone or via **secure portal messaging** within **TheraNest EHR (by Ensora)** so we can discuss and address your concerns.
- The therapist cannot respond to public reviews due to confidentiality obligations.
- Public reviews may reveal personal information.

Location-based services

- If you use check-in or GPS-based apps, others might infer you are a therapy client if you frequently check in at or near the office.

Social media etiquette

- You are free to disclose that you are in therapy, but the therapist cannot confirm or deny a professional relationship without your written consent.

Complaints and ethical concerns

- If you do not wish to address concerns with the therapist directly, you may contact the Texas Behavioral Health Executive Council (BHEC) or the Texas Board of Examiners of Professional Counselors.

Ongoing updates

- Social media and technology evolve quickly. If you have questions, please discuss them in session.

18) Litigation Policy for Court-Related Services

Therapy is not intended to be used for litigation or legal disputes. The therapist requests that clients and attorneys do not involve the therapist in legal proceedings (including custody matters) and do not request records or testimony for litigation purposes. However, the therapist will comply with a lawfully issued subpoena or court order as required by law.

Hourly charge for time related to court cases or litigation: $300 per hour (includes attorney calls, reports, testimony, preparation, deposition, and court appearances).

If the therapist is subpoenaed to provide records or testimony despite this policy, you agree to pay for all professional time, including preparation, record review, travel (door-to-door), waiting time, and time spent testifying.

Retainers: - Dallas County testimony or deposition: **$1,500** retainer (5 hours at $300 per hour) - Outside Dallas County testimony or deposition: **$2,000** retainer

Retainer is due no later than **48 hours** prior to the litigation event.

If testimony exceeds the included hours, the credit card on file may be charged **$300 per hour** for additional time.

Court and deposition cancellation policy: 48-hour cancellation policy. Cancellations within 48 hours are non-refundable.

Accepted payment methods for court-related services: credit card, money order, or cashier’s check. No personal checks.

Payment for court-related services is required regardless of outcome or whether testimony or records are ultimately used.

The therapist will not perform child custody evaluations and will not provide recommendations regarding possession, custody, access to, or visitation with minor children. The therapist will not provide legal advice. The therapist will not provide medication or medical advice.

If subpoenaed despite this policy and against the therapist’s stated wishes, the therapist reserves the right to terminate the therapeutic relationship and refer to other providers.

19) Signatures

Client (or legal representative) name (printed): _____
Client (or legal representative) signature: _____
Date: ____/____/_____

Therapist name (printed): _____
Therapist signature: _____
Date: ____/____/_____

Witness name (printed, if used): _____
Witness signature: _____
Date: ____/_____/_____

For Therapist use:

☐ Copy of Insurance card in file
☐ Copy of drivers license in file (*for client or caregiver if client is under 18*)

☐ Copy if custody agreement (*if applicable*)

☐ Copy of intake paperwork in file.

To do:

_____