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 document is provided for client information and informed consent not legal advice.*

1) Client Intake Information

Client name: _____ Date of first appointment: ___/___/____

Preferred name (if different): _____

Date of birth: ___/___/____ Age: _____ (Optional) 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:

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-issued order signed by a judge outlining legal decision-making authority and access to mental health records must be provided prior to or at the first appointment. Temporary orders are acceptable only if they are signed by a judge and currently in

effect. Handwritten, unsigned, draft, or informal agreements are not accepted. Services cannot begin until appropriate court documentation is received and reviewed.

2) Communication Consent and Limits

Please indicate your choices.

Secure portal messaging (TheraNest EHR by Ensora) is strongly preferred for any communication that includes protected health information [PHI].

A) Email (scheduling/administrative only); not fully secure): □ I consent □ I do not consent

B) Telephone / Voicemail (may include limited PHI): □ I consent □ I do not consent

C) Text Messaging (scheduling/administrative only; not fully secure): □ I consent □ I do not consent

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.
- ***Important: 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 mental health services from another provider? (Check all that apply.)

□ No □ Yes — psychiatric services □ Yes — individual, group, or family therapy

If yes, please provide:

Provider name: _____

Practice / organization (if known): _____

Provider type: □ Psychiatrist □ Psychologist □ LPC □ LCSW □ LMFT □ Other: _____

Phone: (____) ____-_____ **Email (if known):** _____

Reason for concurrent services (optional): _____

□ I consent to coordination of care with this provider. (recommended)
□ I do **not** consent to coordination of care at this time.

Have you received counseling or psychotherapy in the past?
□ Yes — Provider(s): _____ How long ago: _____
Previous diagnoses (if known): _____
□ No

Are you currently taking prescribed mental health medication? □ Yes □ No

If yes:
Medication(s): _____
Prescribed by**:** _____

Vitamins or supplements (optional): _____

4) Health and Social Information

Health and Lifestyle Information (Optional)

Primary physician: □ Yes □ No If yes, name: _____

Seeing more than one medical specialist: □ Yes □ No. If yes, list: _____

Last physical exam: _____

Medications for physical health (optional):_____

Ongoing physical symptoms or health concerns (optional): _____

Color blind: □ Yes □ No **Allergies (check all that apply):** □ Wheat □ Gluten □ Dairy □ Nuts □

Other: _____

Sleep concerns: □ Yes □ No
If yes (check all that apply):
□ Too little □ Too much □ Poor quality □ Disturbing dreams □ Other: _____

Exercise: Times per week: _____ Duration: _____

Appetite or eating concerns: □ Yes □ No If yes (check all that apply):
□ Eating less □ Eating more □ Bingeing □ Restricting

Significant weight change in past 2 months: □ Yes □ No

Alcohol use: □ Yes □ No In the past month, 4+ drinks in one day: □ Yes □ No

Recreational drug use frequency:
□ Daily □ Weekly □ Monthly □ Rarely □ Never

Tobacco use: □ Yes □ No

Romantic relationship: □ Yes □ No. If yes, how long in relationship: _____ Quality (1–10): _____

Significant life changes or stressors in the past year: □ Yes □ No
If yes, explain: _____

5) Strengths, Preferences, and Goals

Strengths (optional): _____

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

Effective coping strategies you have learned (optional): _____

Goals for therapy:

1. _____
2. _____
3. _____

6) 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	○	○
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)	○	○

Safety Screening

Suicidal thoughts:

- Past two weeks: □ Frequently □ Sometimes □ Rarely □ Never
- More than two weeks ago: □ Frequently □ Sometimes □ Rarely □ Never

History of suicide attempts: □ Yes □ No. If yes, when: _____

Sharing that you've had suicidal thoughts does not automatically lead to hospitalization. Your responses help guide supportive care and safety planning.

7) Occupational and Spiritual Information (optional)

Currently employed: □ Yes □ No Employer or position: _____

Work-related stressors (optional):_____

Education / School (optional):
School name: _____ Current grade or level: _____

Spiritual or religious: □ Yes □ No. If yes, faith or belief (optional): _____

8) Emergency Information

<u>This practice does not provide 24-hour crisis services.</u> If immediate treatment is needed, call **911**, go to the closest emergency room or the hospital covered by your insurance.

Additional crisis support options:

- **988 Suicide and Crisis Lifeline** — Call or text **988** (24/7)
- **Crisis Text Line** — Text **HOME** to **741741** (24/7)
- **Poison Control** — **1-800-222-1222** (24/7, U.S.)

Therapists may occasionally be unavailable due to travel, illness, or scheduled time off. During these times, messages may be returned when the therapist is next available.

When clinically appropriate and scheduling allows, **another licensed therapist associated with the practice may be available for backup or urgent support**. Availability is not guaranteed and does not replace emergency services.

For urgent safety concerns when your therapist is unavailable, please use the crisis resources listed above.

9) Emergency Contact

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

10) Family Mental Health History (Optional)

*If a family side is checked, this indicates **Yes**. Check **No** only if the condition is not known to be present in your family.*

Condition	No	Maternal	Paternal	Both
Depression	□	□	□	□
Bipolar disorder	□	□	□	□
Anxiety disorder	□	□	□	□
Panic attacks	□	□	□	□
Schizophrenia or other psychotic disorder	□	□	□	□
Substance use or addiction	□	□	□	□
Eating disorder	□	□	□	□
Learning disability or neurodevelopmental condition	□	□	□	□
Significant trauma history	□	□	□	□
Suicide attempt or death by suicide	□	□	□	□
Chronic medical illness	□	□	□	□
Other (please specify): _____	□	□	□	□

11) Appointments and Attendance Policy

Your appointment time is reserved specifically for you.

- Cancellations or rescheduling with less than 24 hours' notice are considered late cancellations and are charged a **$100 administrative fee**.
- Missed appointments (no-shows) are also charged a **$100 administrative fee**. These fees are not covered by insurance and are not waived by rescheduling.

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. This exception does **not** apply to no-shows. *If you arrive late, the session will still end at the scheduled time.*

Telehealth option:
If you anticipate being late, please contact us as soon as possible. When clinically appropriate and scheduling allows, an in-person session may be converted to telehealth.

Attendance concerns:
An attendance issue includes late cancellations and/or no-shows. After two attendance issues within a six-month period, scheduling needs will be reviewed with your therapist, as permitted by law. Repeated attendance issues may result in termination of services. Clients who have not attended an appointment for **60 days** may be discharged from care.

12) Confidentiality

Your therapy services are confidential. Information is not shared without your written permission, except in situations where disclosure is required or allowed by law. Disclosure is limited to the minimum necessary when required.

There are certain situations where a therapist may need to share information, including:

- Suspected abuse or neglect of a child, elderly person, or disabled individual
- Risk of serious harm to yourself or to others
- Court orders or other legal requirements
- Legal proceedings where mental health records are legally relevant
- Professional consultation, supervision, or quality assurance (only the minimum information needed)
- Billing, payment, and healthcare operations

If disclosure is required by law, you may be responsible for any costs related to record preparation or legal involvement, including the therapist's hourly rate for time spent reviewing records, responding to requests, travel, or testimony. *If you have questions or concerns about confidentiality, please discuss them with your therapist*.

13) Payment Policy and Insurance Information

Payment (or copay) is due at time of service unless otherwise arranged.

Primary Insurance
Insurance carrier: _____ Member ID #: _____
Subscriber name: _____ Subscriber DOB: ___ / ___ / ____
Provider/Member Services phone: (____) ____-_____

Estimated co-pay per session: $_____ Annual deductible: $_____
Deductible met this year? □ Yes □ No □ Unsure

Secondary Insurance (if applicable)
Insurance carrier: _____ Member ID #: _____
Subscriber name: _____ Subscriber DOB: ___ / ___ / ____
Provider/Member Services phone: (____) ____-_____

Estimated co-pay per session: $_____ Annual deductible: $_____
Deductible met this year? □ Yes □ No □ Unsure

Self-Pay / Cash Pay (No insurance)

□ I will be paying privately and do not wish to use insurance. *Self-pay clients have the right to receive a Good Faith Estimate of expected charges upon request.*

Payment method: □ Credit/Debit □ HSA/FSA □ Other: _____

Fees

Provider type	Session fee
Fully licensed clinician	$200
LPC Associate	$100
MA practicum intern	$60

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.

Adult Telehealth consent (age 18+):

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

Minor Telehealth consent (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 provides individual and group art therapy and counseling services for children, adolescents, and adults. Participation in therapy is voluntary, and you may withdraw your

consent at any time. Therapy involves both potential benefits and risks. You are encouraged to ask questions and discuss any concerns about your treatment at any time.

You understand that:

- You are responsible for knowing your insurance coverage, including co-pays and deductibles.
- Any fees not paid by or recouped by insurance are your responsibility.
- Late cancellation and no-show fees are generally not covered by insurance.
- If you have a concern about billing, please contact our office at **(972) 544-6633,** or send a secure message through the **TheraNest (Ensora) client portal** so we can attempt to address the issue promptly. You have the right to receive a fair response within a reasonable period of time.

16) Release of Information (Authorization)

Client name: _____ Date of Birth: ___ / ___ / ____
Client ID (if applicable)**: _____**

I authorize **Davis Art Therapy and Counseling** to exchange information with the following person or organization for the purposes indicated in this authorization.

Name of person or organization:_____

Contact information (phone, fax, or email):_____

This authorization allows **reciprocal communication** between my therapist and the party listed above, limited to the information I have authorized below.

Information authorized (*check all that apply*):

□ My mental health records (*minimum necessary*).

□ Photographs of artwork created in therapy (*clinical record only*).

□ Photographs of artwork for training or professional consultation (*de-identified*).

□ Coordination of care with other healthcare providers (*minimum necessary*).

□ Professional supervision or consultation purposes.

□ Other (*please specify*): _____

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):

□ On this date: ___ / ___ / ____ □ Upon the following event or condition: _____

If no option is selected, this authorization will expire 60 days after discharge:

17) 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.

18) Social Media and Technology Policy

To protect your privacy and the therapeutic relationship, the therapist does not accept friend or contact requests from current or former clients on social media (e.g., Facebook, Instagram). The therapist does not follow clients on personal accounts.

Clients are welcome to view or share content from the public Davis Art Therapy and Counseling and Dallas Art Therapy social media pages.

Communication and Confidentiality

Please do not use social media messages, comments, tags, or public posts to contact the therapist. These platforms are not secure and may compromise confidentiality.

For communication between sessions, please use:

- Secure portal messaging through **TheraNest (Ensora)**
- Phone or text: **(972) 544-6633**

Standard email is not fully secure and should be used only for administrative purposes. Written communications (including portal messages) may become part of your clinical record.

Records and Technology

The practice uses **TheraNest (Ensora)**, a HIPAA-compliant electronic health record system, to store clinical notes, billing, and related documentation.

HIPAA-compliant AI tools may be used to assist with secure documentation (such as note drafting or formatting). AI is **not** used for diagnosis or clinical decision-making. All records remain confidential and securely stored.

In the event of the therapist's death or incapacity, a designated licensed professional or custodian will manage records in accordance with Texas law and professional standards.

Reviews, Privacy, and Location Services

If you have concerns about services, please contact the therapist directly by phone or secure portal message so they can be addressed appropriately. Due to confidentiality requirements, the therapist cannot respond to public reviews.

Public reviews or social media activity may unintentionally disclose personal information. If you use location-based or check-in apps, others may infer you are a therapy client.

You are free to share that you are in therapy; however, the therapist cannot confirm or deny a professional relationship without your written consent.

Technology and social media evolve. Questions or concerns may be discussed in session.

19) Litigation Policy for Court-Related Services

Therapy is not intended for use in legal disputes or litigation. Clients and attorneys are asked not to involve the therapist in legal matters (including custody disputes) or to request records or testimony for litigation purposes. The therapist will comply with a lawfully issued subpoena or court order, as required by law.

Court-Related Fees

- Hourly rate: $300 per hour
  (includes record review, preparation, attorney communication, depositions, travel, waiting time, and testimony)
- Retainers (required in advance):
  - Dallas County: $1,500 (5 hours at $300/hr)
  - Outside Dallas County: $2,000
- Retainers are due no later than 48 hours before the scheduled court-related service.
- If time exceeds the retainer, additional time may be charged to the card on file at $300 per hour.

Cancellations and Payment

- 48-hour cancellation policy applies to all court-related services.
- The cancellations within 48 hours are nonrefundable.
- Payment is required regardless of outcome or whether records or testimony are ultimately used.
- Accepted payment methods: credit card, money order, or cashier's check (no personal checks).

Scope & Limitations

- The therapist does not perform child custody evaluations.
- The therapist does not provide legal advice or recommendations regarding custody, possession, access, or visitation.
- The therapist does not provide medical or medication advice.

If the therapist is subpoenaed despite this policy and against the therapist's stated wishes, the therapist reserves the right to terminate the therapeutic relationship and provide referrals to other providers.

20) Your Rights Under Texas Law (Texas Health and Safety Code §181.105; HB 4224)

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

To request records you may:
• Submit a written request or authorization
• Email: info@dallasarttherapy.org
• Mail: 2007 N. Collins Blvd. #411, Richardson, TX 75080
• Phone: (972) 544-6633

This notice does not replace the Notice of Privacy Practices. This practice is regulated by the **Behavioral Health Executive Council (BHEC)**.
• Phone: (512) 305-7700
• Website: https://bhec.texas.gov/contact-us/

Consumer Complaints
If you wish to file a consumer complaint regarding access to records or other consumer concerns, you may contact: Texas Office of the Attorney General – Consumer Protection Division
https://www.texasattorneygeneral.gov/consumer-protection/file-consumer-complaint

For questions related to HB 4224 posting requirements: HCR_PRU@hhs.texas.gov

21) Acknowledgment and Consent

I acknowledge that I have read and understand the information contained in this intake packet. I have had the opportunity to ask questions and have received satisfactory answers. I agree to the terms and policies outlined and consent to participate in therapy services with Davis Art Therapy and Counseling.

Adult Client (18+) Client name (printed): _____

Client signature: _____ Date: ___ / ___ / ____

□ **Card on File Authorization:** I authorize a credit/debit card to be kept on file and charged according to the Payment Policy.

Minor Client (under 18) Client Name (printed): _____

Client Signature (if appropriate): _____ Date: ___ / ___ / ____

Parent / Legal Guardian #1

Name (printed): _____ Signature: _____

Date: ___ / ___ / ____ □ **Card on File Authorization:** I authorize a credit/debit card to be kept on file and charged according to the Payment Policy.

***Parent / Legal Guardian #2**

Name (printed): _____ Signature: _____

Date: ___ / ___ / ____

**When required by court order or custody agreement, consent from both parents or legal guardians is required for treatment.*

Therapist Acknowledgment

Therapist name (printed): _____ Therapist Signature: _____

Date: ___ / ___ / ____