Mind Metier

Allisha Bonneaux MEd, CSC, LPC

Counseling Intake Form

Note: This information is confidential

Demographic Information:

Name:_____Date: _____

Birth Date/Place_____Relationship Status: _____

Mailing Address _____

Home Phone:_____Cell Phone: _____

Email Address:_____May we email you? _____

Is it okay to communicate by text message?____Yes____No Referred by: _____

Preferred Appointment Reminder Method:____Voice Mail ___Text Message ___Email ___Phone Call

Emergency Contact: _____ Contact Phone: _____

Employer:_____Work Phone: _____

Please list any children and ages: _____

_____

Highest Grade/Degree_____Type of Degree: _____

Insurance Information:

Name of Insured_____ Insured's Workplace _____

Primary Insurance Company_____ Phone _____Co-Pay Amt. _____

ID#_____Group ID# _____

Secondary Insurance Company _____ Phone _____Co-Pay Amt. _

_____

ID#_____ Group ID# _____

Financial Responsibilities:

(1) The client (or client's guardian, if a minor) is responsible for the payment for all services rendered. (2) The client is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.(3) Clients are responsible for the payment of co-pays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service.

Child Custody Issues:

Mind Metier PLLC does not make recommendations for custody of children in disputed cases. Such recommendations are beyond the scope of our services.

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Current Concerns:

Reason for seeking Counseling: _____

When did this begin? (give dates) _____

What do you hope to accomplish in counseling? _____

Behavior – Place an X by any of the following behaviors that apply to you:

- ☐ Overeating
- ☐ Temper outbursts
- ☐ Aggressive behavior
- ☐ Phobic avoidance
- ☐ Work too hard
- ☐ Concentration difficulties
- ☐ Sleeping problems
- ☐ Can't keep a job
- ☐ Loss of control
- ☐ Lack of Motivation
- ☐ Withdrawal
- ☐ Suicidal thoughts
- ☐ Drink too much
- ☐ Impulsive reactions
- ☐ Crying
- ☐ Take drugs
- ☐ Take too many risks
- ☐ Procrastination
- ☐ Compulsions
- ☐ Smoking Vomiting
- ☐ Nervous tics

Feelings – Place an X by the following feelings that apply to you:

- ☐ Unhappy
- ☐ Angry
- ☐ Regretful
- ☐ Fearful
- ☐ Optimistic
- ☐ Jealous
- ☐ Depressed
- ☐ Conflicted
- ☐ Lonely
- ☐ Hopeful
- ☐ Energetic
- ☐ Others:
- ☐ Happy
- ☐ Sad
- ☐ Anxious
- ☐ Excited
- ☐ Relaxed
- ☐ Annoyed
- ☐ Guilty
- ☐ Hopeless
- ☐ Panicky
- ☐ Tense
- ☐ Bored
- ☐ Restless
- ☐ Contented
- ☐ Helpless
- ☐ Envious

Physical – Place an X by the following symptoms that apply to you:

- ☐ Stomach Trouble
- ☐ Dizziness
- ☐ Fatigue
- ☐ Tension
- ☐ Tremors
- ☐ Bowel disturbances
- ☐ Watery eyes
- ☐ Headaches
- ☐ Tics
- ☐ Burning or itchy skin
- ☐ Back Pain
- ☐ Unable to relax
- ☐ Hear things
- ☐ Numbness
- ☐ Skin Problems
- ☐ Dry Mouth
- ☐ Twitches
- ☐ Rapid heart beat
- ☐ Fainting spells
- ☐ Excessive sweating
- ☐ Hearing problems
- ☐ Muscle Spasms
- ☐ Palpitations
- ☐ Chest pains
- ☐ Sexual disturbances
- ☐ Blackouts
- ☐ Tingling
- ☐ Visual disturbances

How would you rate your current physical health? (Place X by choice)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

How many times a week do you generally exercise? _____

What types of exercise do you enjoy? _____

Are you currently experiencing any chronic pain?_____Yes_____No

If yes, please describe: _____

How often do you drink alcohol? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

How often do you engage in recreational drug use?_____Daily_____Weekly ☐ Monthly ☐ Infrequently ☐ Never

Are you currently in a romantic relationship?_____Yes_____No

If yes, for how long? _____

On a scale of 1 – 10, how well would you rate your relationship? _____

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Coaching, Consulting, and Counseling
Allisha Bonneaux MEd, CSC, LPC
MindMetier.net
Phone: 409.330.4868

What significant life changes or stressful events have you experienced recently?

Have you received psychological, psychiatric, or counseling services in the past?_____Yes ☐ No

If yes, what was your concern at the time? _____

If yes, with whom and what was the result? _____

If yes, what diagnosis did you receive? _____

List any psychiatric medications you may have been prescribed. _____

Family Mental Health History – Place an X on any of the following that apply:

☐ Alcohol/Substance Abuse
☐ Domestic Violence
☐ Obsessive Compulsive
☐ Anxiety
☐ Suicidality
☐ Relational Issues
☐ Depression
☐ Temper
☐ Child Abuse
☐ Bi-polar

Social:

Do you have trusted friends with whom you can share your concerns?_____

How long have you been associated with those you consider to be your closest friends? _____

What do you and your friends like to do together? _____

How would you describe your relationship with your family? _____

What is your involvement in the community? (e.g. volunteering, church, schools, etc)_____

How would you describe your spiritual life? _____

Are you involved in any current or pending civil or criminal litigation/s, lawsuit/s, or divorce/custody disputes? If yes, please explain:_____

What are your main worries and fears? _____

What are your most important hopes and dreams for your future? _____

What gives you the most happiness or pleasure in life? _____

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. Protected Health Information (PHI) is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care serves to you, to pay your health care bills, to support the operation of the physician's practice, and by any other use required by law. Treatment: We use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services from insurance companies. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization:

- If you are determined to be in imminent danger of harming yourself or someone else
- If you disclose abuse or neglect of children, the elderly, or a disabled person(s)
- If you disclose sexual misconduct by a mental health professional
- To qualified personnel for certain kinds of audits or evaluations
- In a criminal court proceeding
- In legal or regulatory actions against a professional
- In proceedings in which a claim is made about one's physical, emotional, or mental condition
- When disclosure is relevant to any suit affecting the parent-child relationship, which includes divorce and child custody deliberations
- Where otherwise legally required

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the law. Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time in writing except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative

action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may request that any part of your protected health information not be disclosed for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state that specific restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction with you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Heathcare Professional. You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from this office, upon request.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by your notification and we will not retaliate against you for filing a complaint. If you have objections to his form, please contact Allisha Bonneaux at 409-330-4868.

I have read the notice listed above.

_____ _____

Client Signature (Client's Parent/Guardian if under 18 years old.) Date:

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Allisha Bonneaux MEd, CSC, LPC

Counselor Limits of Confidentiality

Your counselor recognizes that confidentiality is essential to effective counseling. In order for counseling to work best, you must feel safe about sharing your personal information with your counselor. Under most circumstances, all information about you, in written or verbal form, obtained in the counseling process (including your identity as a client) will be kept ethically and legally confidential. Information will not be disclosed to any outside person(s) or agency without your written permission except in certain situations, which include, but are not limited to:

- If you are determined to be in imminent danger of harming yourself or someone else
- If you disclose abuse or neglect of children, the elderly, or a disabled person(s)
- If you disclose sexual misconduct by a mental health professional
- To qualified personnel for certain kinds of audits or evaluations
- In a criminal court proceeding
- In legal or regulatory actions against a professional
- In proceedings in which a claim is made about one's physical, emotional, or mental condition
- When disclosure is relevant to any suit affecting the parent-child relationship, which includes divorce and child custody deliberations
- Where otherwise legally required
- Insurance providers and other third-party payer are given information that they request regarding services to clients

A court may not consider information that you also share, outside if counseling, willingly and publicly, protected or confidential. If you have questions about specific situations or any aspects of confidentiality, please feel free to discuss your concerns with you counselor. You may also contact: www.dshs.state.tx.us/counselor/default.shtm.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Client Signature (Client's Parent/Guardian if under 18 years old.) Date:

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Release of Information & Consent Form

Client Name:_____ Date of Birth: _____

Address_____Phone: _____

I,_____, hereby authorize the release and

exchange of information specified below between:

_____
Name/Title or Organization Name (i.e., Psychiatrist, Primary Care Physician, or entity

_____
Organization Address

_____
Phone/Fax

Mind Metier PLLC

Allisha Bonneaux
Phone:
409.330.4868

This release of information shall be limited to the following specific types of information:

☐ Assessment	☐ Nursing/Medical Information	☐ Demographic Information
☐ Diagnosis	☐ Toxicological Reports/Drug Screens	☐ Current Treatment Update
☐ Psychosocial Evaluation	☐ Discharge/Transfer Summary	☐ Progress in Treatment/Notes
☐ Psychological Evaluation	☐ Medication Management Info.	☐ Continuing Care Plan
☐ Treatment Plan or Summary	☐ Presence/Participation in Treatment	☐ Educational Information
☐ Other_____	☐ Other _____	

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, and when appropriate, coordinate treatment services. If other purposes, please specify: _____

This authorization for release of information is made with informed consent, and this consent is subject to revocation by written instructions of the undersigned at any time by sending notification to Allisha Bonneaux MEd, CSC, LPC. However, a revocation is not valid to the extent that parties have acted in reliance on such authorization. The information is confidential and any redisclosure by the recipient is prohibited, unless expressly permitted by the client or someone authorized to act on his/her behalf. I understand that this authorization authorizes the release of all medical records including psychiatric, Alcohol, and Drug Abuse.

_____
Client Name (Printed)

_____
Client Signature Date