Evelyn A. Stone, LCSW-S

Individual, Adolescent, & Family Counseling

Evelyn A. Stone, LCSW, CFLE
Individual, Adolescent & Family Counseling

3960 Broadway Blvd., Suite 220-S
Garland, TX 75043
Tel: (972) 523-0083
Fax: (972) 226-8402

INDIVIDUAL INTAKE FORM

Welcome to Counseling. We look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help us to better understand your situation as well as potential solutions. Please note - the information is confidential, for our use only, and will not be released to anyone without your written permission.

Personal Information

Client Name: _____ Date of Birth: _____ Age: _____

Guardian Name: (If Minor) _____

Street Address: _____ City/State: _____ Zip Code: _____

Sex: ☐ Female ☐ Male Religious Affiliation (if any): _____

Home Phone _____ Is it okay to leave a message? ☐ Yes ☐ No

Work Phone _____ Is it okay to leave a message? ☐ Yes ☐ No

Cell Phone _____ Is it okay to leave a message? ☐ Yes ☐ No

Email Address: _____ May we e-mail you? ☐ Yes ☐ No

Payment Information

Insurance Information: **(If EAP, Authorization #_____)**

Name of Insurance Company: _____ Insurance Co. Phone # (Mental Health): _____

Policy Owner's Name: _____ Policy Owner's Date of Birth: _____

Policy Owner's SS#: _____ Insurance ID #: _____ Policy or Group#: _____

Policy Owner's Address (only if different than above): _____

Please be prepared to provide your insurance card & ID so that we may make a copy.

Emergency Contact Information

Name: _____ Relationship: _____

Street Address: _____ City/State: _____ Zip Code: _____

Home Phone _____ Work Phone _____

Cell Phone _____ Is it okay to leave a message? ☐ Yes ☐ No

Referral Source

How did you learn about this office? (Please check one and provide name as indicated):

☐ Insurance Co. _____ ☐ Physician _____ ☐ Advertising (source) _____

☐ Internet _____ ☐ Friend _____ ☐ Other _____

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Client Services Agreement

Name of Client: _____ Name of Responsible Party (if different): _____

TREATMENT:
I understand that I must be committed to attend sessions on a consistent basis in order to receive the greatest benefit from therapy. Although I may stop therapy at any time, I agree to inform my therapist of my decision **prior** to my last visit. If my therapist believes that I can receive more effective treatment elsewhere, I will be given referrals. I understand that I may not attend a session if I am under the influence of alcohol or drugs, or if I am in possession of a dangerous weapon. My signature below indicates my desire and consent to receive mental health services from Evelyn Stone Counseling (also called the Therapist).

PAYMENT & INSURANCE REIMBURSEMENT:
I understand that I, (the client) am fully responsible for the payment of all fees for services provided regardless of any insurance coverage I may have. I understand that it is The Therapist's policy that the fee for any session is payable at the beginning of the session. We accept cash, checks or credit cards as forms of payment. *All sessions are 45 - 50-minutes in length*. The fee for an initial intake session is $130.00. Follow up session fees for individuals, couples or families is $110.00. While sessions are not generally conducted by phone, if an emergency phone consultation is initiated by the client, the first 10-minutes are at no charge. However, $25.00 will be billed to your account for each subsequent 15-minute period. This office offers a sliding scale fee based on client income.

If any documentation is needed to completed by the therapist beyond the regular scope (such as reports, disability paper work), there is a fee. (See Form) Payment for form completion is required prior to form completion. The therapist will be given 7-14 days to complete the paperwork.

I understand that if I have insurance, the Therapist may file the claim on my behalf or will provide me with the necessary information so that I can file the claim. **I understand that I am ultimately responsible for any therapy fee(s) not covered by my insurance carrier.** Co-pays and non-covered services are payable at time of service. In the event that insurance is billed on my (the client) behalf, I authorize payment of mental health benefits to Evelyn Stone (Counseling).

CANCELLATIONS AND MISSED APPOINTMENT POLICY
I understand that unless a verifiable emergency exists, I must cancel or re-schedule my appointment **24 hours in advance**. Same-day cancellations will incur a $30 fee applied to my account and my failure to attend a scheduled appointment without cancellation (a "no-show") will incur a $40 fee to my account. I can expect an invoice to be mailed directly to me if I do not show up or timely cancel a scheduled appointment. The Therapist's voicemail and text record the day and time of all messages left. If I cancel appointments on a consistent basis or miss appointments twice in a row without reasonable cause, the therapist reserves the right to refer me elsewhere for services. I understand that this policy is not meant to be punitive**, but instead is to request consideration for the professionals who are providing me a valuable service.** My appointment time is reserved for me at the exclusion of others who may be waiting to see the therapist. Since the therapists' practice is fee for service, my late cancellation or failure to show for an appointment may result in a loss of income for the therapist.

My signature below indicates that I have read, understand, and agree to the statements made above regarding Treatment, Payment & Insurance Reimbursement, and Cancellations and Missed Appointment Policy.

Responsible Party/Client signature: _____ Date: _____/_____/_____

Client (if different/Minor) signature: _____ Date: _____/_____/_____

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Consent for Counseling Services

Client Name: _____

I, _____, understand that I have the right to agree to, or to refuse mental health services provided by Evelyn Stone Counseling. By signing below, I am indicating my desire to receive Mental Health services (initial here):_____.

Limits of Confidentiality

I understand that the contents of a counseling, intake, or assessment session are protected under the confidentiality laws of the State of Texas. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this office not to release any information about a client without a signed release of information. Noted exceptions are as follows:

- Signed authorization to release information to a specific individual or organization
- Therapist determination that you may harm yourself or someone else
- Disclosure of abuse, neglect, or exploitation of a child, the elderly, or disabled
- Disclosure of professional misconduct of another mental health professional
- Court order or requirement by law to disclose information
- Prenatal exposure to controlled substances
- In the event of a client's death (the spouse or parents of a deceased client have a right to access their child's or spouse's records)
- Minors/Guardianship (parents or legal guardians of non-emancipated minor clients have the right to access the client's records)
- Insurance Companies (only information required for billing purposes)

By signing my initials next to the statements below and signing this document, I agree to the following statements:

_____ I am consenting to receive mental health services from Evelyn Stone Counseling.

_____ I understand my right to confidentiality and the above noted exceptions.

Client Name (please print): _____

Client Signature: _____ Date: _____/_____/_____

If Client is a minor:

Parent/Guardian _____ Date: _____/_____/_____

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Consent to Use and Disclose Your Health Information (HIPPA)

This form is an agreement between you, and Evelyn Stone Counseling (Evelyn Stone, LCSW-S, CFLE). When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: _____

When we consult, evaluate, diagnose, treat, and/or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read this notice and are aware our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information is available to you upon request.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, the new information will be available in our office or you can request a copy by calling us at 972-523-0083

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will need to submit any limitation requests in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do accept them, we commit to abide by the limitations that you have requested. After you have signed this consent, you have the right to revoke it by submitting a written request. Upon receipt of your request, we will discontinue using or sharing your PHI. However, please be advised that we may have already used or shared some of it, and that information cannot be retracted.

Client Signature: _____ Date: _____/_____/_____

If Client is a minor:

Parent/Guardian _____ Date: _____/_____/_____

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"NO SHOW" AND "LATE CANCELLATION" POLICY

*(This agreement must be signed prior to your being seen)**

I appreciate your attention to our "no show" and "late cancellation" policy. Many people stay so busy that no shows and late cancellations have become an increasing problem. If you are not going to be here for your appointment, I require at least 24 hours' notice so as to allow someone else the opportunity to schedule in your time slot. It is understandable that at stressful times that are prone to create occasional cancellations. However, in order for me to effectively schedule and provide services, I require that you accept and adhere to this NoShow/Late Cancellation policy. If you do not complete and sign this sheet, the policy will apply at Evelyn Stone Counseling. This policy is in effect immediately. *

I want to emphasize that insurance & EAPs will NOT pay for No Shows or Late Cancellations. They are your responsibility.

I understand that I will be charged a No Show fee of $40 if I do not keep an appointment, or a Late Cancellation fee of $30 if I cancel with less than 24 hours' notice.

Signed by Client/Adult parent _____ Date_____

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DISABILITY FORM REQUEST POLICIES

(Includes requests for Short Term Disability, Long Term Disability, FMLA forms, etc. to be completed) If you are planning to seek disability and will be requesting information to be released by your provider, **PLEASE READ THE FOLLOWING CAREFULLY**.

1. Prior to completing ANY forms related to these requests, our policy requires that you must keep 3 consecutive visits.
2. There will be a fee charged to have these forms completed which may range from $25.00 - $75.00.

FORM FEES:

$25.00: Any forms that are 2 pages and under
$50.00: Any forms that are 3 to 5 pages
$75.00: Any forms that are six or more pages

3. Fees associated with these requests must be paid before the forms are given to the provider to complete.
4. Once these requirements are met, it may take 7 – 14 business days to complete these forms.

I have read and understand the policy for disability (or other) form completion. I will abide by the guidelines.

Signed by Client/Adult parent_____ Date_____