

**Person to Contact in Case of Emergency**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Best Contact Number \_\_\_\_\_  
Alternative Contact Number \_\_\_\_\_

Office Use Only  
Intake Date \_\_\_\_\_  
Reason for referral \_\_\_\_\_  
Counselor \_\_\_\_\_

**THE COUNSELING PLACE  
ADULT INTAKE FORM**

**Yearly Family Income:** \_\_\_\_\_

**Full Name of Client** \_\_\_\_\_

Social Security No. \_\_\_\_\_ Driver's License No. \_\_\_\_\_ State: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ Religion \_\_\_\_\_

Email Address \_\_\_\_\_

Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Job Title \_\_\_\_\_ Education (Yrs. Completed) \_\_\_\_\_

Relationship Status (Circle): Single / Dating/ Engaged/ Married / Separated / Divorced / Widowed / Cohabiting

**Spouse Information (if applicable)**

Name of Spouse \_\_\_\_\_ No. of years married \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ Religion \_\_\_\_\_

Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State/Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Education (Yrs. Completed) \_\_\_\_\_

Job Title \_\_\_\_\_

**Children**

Full Name	Sex	Age	Comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who is currently living in your home?  
\_\_\_\_\_

Why are you currently seeking counseling? \_\_\_\_\_  
\_\_\_\_\_

List your current concerns in the order of their importance \_\_\_\_\_  
\_\_\_\_\_

Is there a history of any of the following? (Please check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Suicide Attempts                          | <input type="checkbox"/> ADD / ADHD  |
| <input type="checkbox"/> Major Depression                          | <input type="checkbox"/> Grief Issues  |
| <input type="checkbox"/> Anxiety                                   | <input type="checkbox"/> Sexual Abuse  |
| <input type="checkbox"/> Domestic Violence                         | <input type="checkbox"/> Contact with Child Protective Services<br>or similar agency |
| <input type="checkbox"/> Drug or Alcohol Abuse<br>(Self or Family) | <input type="checkbox"/> Other _____   |

What do you hope to gain from counseling at this time? \_\_\_\_\_

Have you had any previous counseling? \_\_\_\_\_ Dates of therapy: From \_\_\_\_\_ To \_\_\_\_\_

Name of previous therapist \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Issues of concern

Reason for termination of therapy

**Medical History**

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Current Medications \_\_\_\_\_

Previous Medications \_\_\_\_\_

Check the behaviors and symptoms that occur to you more often than you like them to take place:

- |                           |                           |                             |
|---------------------------|---------------------------|-----------------------------|
| _____ aggressions         | _____ fatigue             | _____ sexual difficulties   |
| _____ alcohol dependence  | _____ hallucinations      | _____ sick often            |
| _____ anger               | _____ heart palpitations  | _____ sleeping problems     |
| _____ antisocial behavior | _____ high blood pressure | _____ speech problems       |
| _____ anxiety             | _____ hopelessness        | _____ suicidal thoughts     |
| _____ avoiding people     | _____ impulsivity         | _____ thoughts disorganized |
| _____ chest pain          | _____ irritability        | _____ trembling             |
| _____ depression          | _____ judgment errors     | _____ withdrawing           |
| _____ disorientation      | _____ loneliness          | _____ worrying              |
| _____ distractibility     | _____ memory impairment   | _____ other (specify)       |
| _____ dizziness           | _____ mood shifts         | _____ cutting               |
| _____ drug dependence     | _____ panic attacks       | _____                       |
| _____ eating disorder     | _____ phobias/fears       | _____                       |
| _____ elevated mood       | _____ recurring thoughts  | _____                       |

List additional illness, physical conditions or complaints:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## VICTIM ASSISTANCE PROGRAM

You are eligible for counseling because you have been referred by the Richardson Police Department under one or more of the following conditions:

- a) the Victim of a violent crime, or the family member of a Victim;
- b) an information report taken by the Police Department for Family Conflict, Family Disturbance, or Family Violence;
- c) an information report taken by the Police Department for suicidal thoughts or actions;
- d) a family member or close friend has died, and you were directly affected.

The Richardson Police Department contracts with The Counseling Place to provide up to six (6) sessions of counseling per family member involved, per report at **NO CHARGE TO YOU**. However, the police department does not pay for appointments cancelled without 24-hour notice or for your failure to show for a scheduled appointment. **You will be charged a \$35.00 fee for a late cancel or no-show.**

Should The Counseling Place, at their discretion, file a CVC claim on your behalf for counseling services rendered, you are still responsible for payment of the account balance. If for any reason you become ineligible for CVC benefits or for charges not paid by CVC or your insurance carrier (if applicable) to The Counseling Place for your account, you are still responsible for payment of services received from The Counseling Place. You also agree, if The Counseling Place files a CVC claim for you, to provide your insurance information at the time of the filing and to use CVC funds that you received for the purpose for which they are intended.

## ALLIANCE WORKFORCE PARTNERS (AWP)

The Counseling Place is a provider for AWP, which manages the **Employee Assistance Program** for employees of many organizations, including the City of Richardson. All **sessions must be approved in advance** by AWP. The plan with AWP is to provide for short-term counseling. Sessions approved by AWP do not require a client co-pay. **You will be charged a \$35.00 fee for a late cancel or no-show.**

In order to protect client confidentiality, The Counseling Place will not communicate directly with the client's employer. If a client is required to report to a supervisor regarding therapy attendance, the client needs to communicate directly with the supervisor.

Clients who wish to continue therapy beyond the approved number of sessions may continue with his or her therapist with The Counseling Place if both therapist and client agree continued care is beneficial. The client will be required to pay a fee for services. Fees will fall on The Counseling Place's sliding scale fee schedule, determined by the client's household income. We encourage these clients to consult with their medical/health benefits representative to determine if continued mental health services are covered by his/her plan. If continued therapy services are covered by the client's insurance, then the therapist can provide the client with the documentation necessary to file for reimbursement. The Counseling Place will not submit any billing on behalf of the client. Payment will be due at the time services are provided.

**The Counseling Place  
Counseling Fee Agreement Form**

The Counseling Place fee for a 50-minute individual, family or marital counseling session is determined by the client's ability to pay. The fee scale is based on a sliding scale determined by annual gross family income.

<u>Income</u>	<u>Fee per session</u>	<u>Income</u>	<u>Fee per session</u>
\$10,000 and under	\$35	\$50,000 – 59,999	\$60
\$10,000 – 19,999	\$35	\$60,000 – 69,999	\$70
\$20,000 – 29,999	\$35	\$70,000 – 79,999	\$80
\$30,000 – 39,999	\$40	\$80,000 – 89,999	\$90
\$40,000 – 49,000	\$45	\$90,000—99,999	\$95
		\$100,000 and up	\$100

**PAYMENT:** Payment for the counseling session is **due at the time of the appointment**, unless prior arrangements have been made. Cash or personal checks made out to “The Counseling Place” are acceptable for payment. **A returned check fee of \$25.00 will be charged on any returned check.** If you have an outstanding balance, you may be mailed a statement requesting payment from the agency. Any outstanding balances not paid within 60 days may be turned over to a collection agency. Limited personal information about you will be given out in order to collect outstanding balances.

**INSURANCE BENEFITS:** Some insurance companies will pay part of counseling fees, others will not. The Counseling Place will provide you a receipt you can send in to your insurance company for possible reimbursement. **We will not accept your co-pay and file insurance for you.** Health insurance companies often require that one of our counselors diagnose your mental health and indicate that you have an “illness” before they will agree to reimburse you. I will inform you of the diagnosis when I fill out the form. Any diagnosis made may become part of your permanent insurance records. *Please check mental health benefits with your insurance prior to beginning counseling.*

**CANCELLATION POLICY:** Clients will be charged **\$35.00** for canceled appointments unless the counselor is notified **24 hours prior to the appointment time**. Exceptions may be made for emergencies. If you are late for an appointment, the session will still end at the scheduled time, and you will be charged for a full session. **Balances for failure to show or a cancelled appointment must be paid before another session can be held.**

**LEGAL FEES:** In the event one of our counselors is requested to provide their services to an outside entity, the following fees will be assessed:

- \$500 upfront for court services
- \$100/hour for court time
- \$150 for court preparation
- \$35 for case copies
- \$25 for case management

**AGREEMENT:** My counselor has reviewed the above policies with me and I understand these policies. After reviewing the fee scale, I agree to pay \$\_\_\_\_\_ per counseling session.

The Counseling Place Director – Debbie Dobbs – 469-283-0344  
Suicide Crisis Line – 214-828-1000

\* Adjustment of fees may be made under special circumstances at the discretion of the Executive Director

# THE COUNSELING PLACE, INC

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

---

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of its Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change its Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

---

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required By Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence,

and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient, under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

---

## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.35 for each page, \$12.00 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

---

## **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer: Debbie Dobbs, Executive Director  
Telephone: 469-283-0242 Fax: 469-519-4150  
E-mail: [Debbie@counselingplace.org](mailto:Debbie@counselingplace.org)  
Address: The Counseling Place  
375 Municipal Dr. Suite 222  
Richardson, Texas 75080

# THE COUNSELING PLACE, INC

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\* YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT \*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please print **client's** name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

---

### For Office Use Only

---

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

---

---

---

# THE COUNSELING PLACE

## Counseling Agreement

**Counseling Relationship:** The counseling relationship is a professional relationship, not a social one. Sessions may be weekly or at intervals necessary to meet the collaborative treatment goals we have agreed upon. Contact will be limited to counseling sessions that you arrange at a predetermined time convenient for both of us. In case of emergency contact The Counseling Place by phone (469-283-0242), or another contact number provided by your therapist.

**Records and Confidentiality:** All of our communication becomes part of a clinical record which is the property of The Counseling Place. Adult files are disposed of seven years after the case is closed. Records of minors are disposed of seven years after the minor's eighteenth birthday. Communication between us is confidential except in the following instances:

- I determine you are a danger to yourself or others
- You disclose abuse, neglect, or exploitation of a child, elder, or disabled person
- I am court ordered to disclose information regarding your case
- You disclose sexual contact with another mental health professional
- You direct me in writing to release your records
- I am otherwise required by law to disclose such information

I may use your case records for the purpose of supervision and professional development with other counseling staff members at The Counseling Place. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

**Outcome of Counseling:** At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing or not continuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these changes can be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

**Client Rights:** Some clients need only a few sessions of counseling; others need several weeks or months. You may end our counseling relationship at any time, although I do ask that you do so in a final session with me. Counseling is a cooperative process between a client and therapist; please discuss any concerns you have openly with me so they can be addressed.

I assure you that my services will be rendered in a professional manner with accepted legal and ethical standards. If at any time you are dissatisfied with my services, please let me know. If I am unable to resolve your concerns, please contact The Counseling Place Executive Director or the appropriate licensing board (LPC, LMFT, LCDC, and LMSW). Numbers are posted in the waiting area.