Mollie Van Deusen, M.S., LPC
Texas License # 66411
940-902-2636
www.SeeMeTherapy.com
seemetherapy@gmail.com
4425 E U.S. Hwy 377 | Granbury, TX 76049

COUNSELING INTAKE FORM

Name of Individual Seeking Counseling:

_____
First Middle Last

Date of Birth: _____ Age:_____ □ Male □ Female

□ Minor (Check here if client is under the age of 18 at the time of first visit)

Responsible Party's Name & Relationship to Client (if different than above or if client is a minor)

_____
First Middle Last

Patient's Address (used for billing and/or correspondence):

_____
Number Street City State Zip

Do I have permission to send mail to this address above? □ Yes □ No _____
(Initials)

Email: _____ Do I have permission to email you? □ Yes □ No _____
Please note any correspondence through email is unsecured. Only use email with this understanding. (Initials)

The undersigned counselor is requesting all these contact numbers in case of emergencies. Your preferred contact number will be used for normal business purposes. Please circle your preferred contact number and place a check mark beside each number where the counselor has permission to leave a message, or send a text message.

Home Phone □ _____ Cell Phone □ _____ Work Phone □ _____
Please note any correspondence through text messages is unsecured. Only use text messaging with this understanding.

Dependents & Any Other Household Members (please include all children. For minor children, indicate who they live with if they do not reside with you.)

_____
Name Relationship Place of Residence (if different than above) Age

_____
Name Relationship Place of Residence (if different than above) Age

_____
Name Relationship Place of Residence (if different than above) Age

_____
Name Relationship Place of Residence (if different than above) Age

FEES

The undersigned counselor may take some insurance and may work for Employee Assistance Programs (EAP). It is your responsibility to verify coverage with your insurance provider or employee assistance program prior to entering treatment. If the undersigned counselor is not in-network with your insurance company, you will likely be responsible for all charges. By initialing here you accept responsibility for payment of services rendered and acknowledge you are responsible for determining coverage by your insurance company.

_____
(Initials)

Codes needed for insurance purposes will be included on your invoice upon request. In most cases insurance companies will provide some level of coverage or reimbursement to you for out of network changes. Please check with you insurance company's policies for filing out of network charges. Payment is expected at time of service. In order to assist clients with the fees for counseling, a sliding scale fee is available to all clients. Fees are based on your gross (total) family income. You may request a re-assessment if there has been a change in financial circumstances. The sliding scale is as follows:

Gross Annual Income	Fee per 50-minute session for individual and family therapy	Client Fee
$0 - $45,000	$60.00	□
$46,000 - $65,000	$80.00	□
$66,000 - $89,000	$100.00	□
$90,000 and above	$120.00	□

Please place a check mark beside the fee scale above which applies to you and initial here that you agree to pay this fee (indicated by your check mark). Adjustments can be made depending on family size.

_____
(Initials)

Additional Fees

Although it is the counselor's duty and goal to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. If you become involved in legal proceedings requiring the counselor's participation, you will be required to pay the counselor's participation even if the other party calls the counselor. The undersigned counselor is not a forensic specialist and therefore does not participate in court issues willingly. Fees for court appearances and for court ordered documentation preparation will be assessed as follows:

- Initial $300 nonrefundable charge for any court appearance or deposition must be paid in advance.
- Any appearance exceeding 3 hours will be billed at $120 per hour. Billable hours include travel time on both ends of appearance.
- Time spent for document preparation (by subpoena), copying files and phone calls will be billed in 30-minute increments at $120 per hour.
- Any billable hours not covered by initial payment must be paid within 7 days of court appearance.

_____
(Initials)

CONFIDENTIALITY

Discussions between you and the undersigned counselor are confidential. No information will be released without your written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: Abuse or neglect of minors; abuse, neglect or exploitation of the elderly; abuse of patients in mental health facil-

ities (618.33 Texas Administrative Code, Ch. 681) criminal prosecutions (611.004 Texas Health & Safety Code, Ch. 611); situations where the counselor has a duty to disclose, or where, in the counselor's judgment it is necessary to warn or disclose (611.004 Texas Health & Safety Code Ch. 611); fee disputes between you and the counselor (611.006 Texas Health & Safety Code Ch. 611; or the filing of a complaint wit the licensing board (611.006 Texas Health & Safety Code, Ch. 611). If you have any questions regarding confidentiality, you should discuss this matter further with the counselor. By signing this information and consent form you are giving your consent for the counselor to share confidential information with all persons mandated by law and with the agency that referred you. You are responsible for providing payment for services rendered, and you are releasing and holding harmless the undersigned counselor from any departure from your right of confidentiality that may result.

_____
(Initials)

EMERGENCY CONTACT INFORMATION

In the event that an emergency arises while I am in counseling, please contact:

Name	Phone Number (with are code please)	Relationship

DUTY TO WARN

In the event that the undersigned counselor reasonably believes that I am a danger, physically or emotionally to myself or another person, I specifically consent for the counselor to warn the person in danger and to contact the following person(s), in addition to medical and law enforcement personnel:

_____
(Initials)

In addition to my primary emergency contact, I consent for the counselor to contact the following person(s) / agency to release information about my treatment (optional):

_____
(Initials)

Name	Phone Number (with are code please)	Relationship

ABOUT AFTER HOURS EMERGENCY

After normal business hours (Monday through Friday, 9:00 a.m. to 5:00 p.m.) should an emergency arise, it is recommended you report to the nearest Emergency Room or call 911 for emergency assistance.

RELATIONSHIPS

Your relationship with the undersigned counselor is a professional and therapeutic relationship. In order to preserve this relationship and abide by the ethical standards of the Texas State Board of Examiners of Professional Counselors (681.32 Texas Administrative Code, Ch 681), it is imperative that the undersigned counselor refrain from any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the undersigned counselor. Clients have the right to terminate the therapeutic relationship at any time. If you choose to terminate the therapeutic relationship, the undersigned counselor asks that you participate in a termination session. The undersigned counselor reserves the right to terminate the therapeutic relationship under the following contritions:

- Lack of progress in the therapeutic process
- Noncompliance with the therapeutic process
- Excessive cancellations

If the undersigned counselor makes the termination decision, references for three other counseling providers will be given to you.

_____
(Initials)

CONSENT TO TREATMENT

I voluntarily agree to receive a Mental Health assessment, care treatment or services, and authorize the undersigned counselor to provide such care, treatment or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment or services, and that I may stop such care, treatment or services that I receive through the undersigned counselor at any time. By signing this client information and consent form, I the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. If you have any questions or need clarification, please let the undersigned counselor know.

_____

Client Signature Date Phone Number (with are code please)

I have received a copy of the client information and consent form.

_____
(Initials)

RISK OF THERAPY

You may learn things about yourself that you do not like. Often, growth con not occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety and pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy.

THERAPY APPOINTMENTS

In regard to therapy, consistency in attendance is extremely important. The undersigned counselor understands that schedules change and unexpected occurrences arise, you may reschedule your appointment when absolutely necessary. The undersigned counselor checks voicemail and other messaging systems through the day during normal business hours. Should you need to contact the undersigned counselor after hours or on the weekend in order to give necessary notice to cancel and reschedule, you may leave a message by calling 940-902-2632.

CANCELLATION POLICY

If you notify the undersigned counselor to cancel an appointment more that 24 hours before your scheduled appointment, there is no charge for canceling or rescheduling. If you miss an appointment without 24 hour notification, you will be charged the full fee.

_____
(Initials)

TELEPHONE CONSULTATIONS

On occasion, it is necessary for a client to contact the counselor by telephone outside of the regular therapy session to discuss an issue. You will be asked to leave a message and the undersigned counselor will make reasonable effort to return your call as quickly as possible. Please limit call time to less than 10 minutes. If this phone consultation needs to continue beyond ten minutes, the conversation may be extended. You will be billed your regular rate for this phone session.

_____
(Initials)

PERMISSION FOR PROFESSIONAL SERVICES FOR A MINOR

I have the legal authority to seek and grand permission for professional services for a minor child. In all divorce and legal separation circumstances, the undersigned counselor must have signed consent from both parents and/or a copy of a divorce decree or custody agreement station you have sole legal authority to make counseling decisions for your minor child.

_____
Signature Relationship to Client

_____
Signature Relationship to Client

CLIENT FAMILY MEMBER SIGNATURES

All family members involved in this therapy need to sign below, indicating an understanding of these policies and procedures. If you have any questions, please discuss them with the counselor BEFORE you sign.

_____
Signature Date

_____
Signature Date

_____
Signature Date

_____
Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED ND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR INFORMATION IS IMPORTANT TO THIS PROVIDER.

OUR LEGAL DUTY

This provider is required by applicable federal and state law to maintain the privacy of your health information. This provider is also required to give you this notice about privacy practices, legal duties, and your rights concerning you health information. This provider must also follow the privacy practices that are described in this notice while it is in effect. This notice will remain in effect until replaced.

This provider reserves the right to change privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. Before this provider makes a significant change in privacy practices, the provider will change this notice and make a new notice available upon request.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by this provider, employees and others that are involved in your care for the purpose of providing counseling services to you. Your protected health information may be disclosed to pay your counseling bills and to support this provider's operations.

For Treatment: We may use your medical information to provide you with treatment or services. We may disclose your medical information to doctors, nurses, technicians, medical students, psychotherapists, or other personnel who are involved in your care. We may disclose medical information about you to people outside this facility who may be involved in your medical care after you leave, such as family members, clergy or others we use to provide services.

Individuals Involved In Your Care or Payment for Your Care: We may disclose your protected health information to a friend or family member or other person specifically designated by you and who is involved in your medical care or to someone who helps to pay for your care.

To Avert a Serious Threat to Health or Safety: We may use and disclose information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Mental Health Oversight Activities: We may disclose your information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations and licensure.

Communicable Disease: We may disclose your protected health information, if authorized, to a person who may have been exposed to a communicable disease or may otherwise be at risk for contracting or spreading the disease or condition.

Abuse or Neglect: We may disclose your protected health information to a public health agent authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your health information to a governmental entity or agency authorized to receive such information if we believe that you have been the victim of abuse, neglect or domestic violence. Disclosure would be consistent with the requirements of applicable federal and state law.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court order. We may also disclose health information about you in response to a valid subpoena, discovery request or other lawful process by no one else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release health information if asked to do so by a law enforcement official; In response to a court order, subpoena, warrant, summons, or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime, if under circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about the criminal conduct at our office; and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities: We may release health record information about you to authorized federal authorities for intelligence, counter-intelligence, and other national security activities by law.

Protective Services for the President and Others: We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or heads of state or conduct special investigations.

Right to Inspect, Copy and Amend: You have a right to inspect and copy all disclosures of information, including treatment summaries. This does not include psychotherapy notes. If you feel any information from any disclosure is incorrect, you have the right to request an amendment. All requests to inspect and copy disclosures must be made in writing to this provider. Denial of requests may occur with some requests. For instance, a request made by one spouse for disclosures occurring during counseling will be denied.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of disclosures we have made of your health record information. Request must be made in writing, state a time period (no longer than six years) and may not include dates before April 14, 2003.

Right to Request Restrictions: You have the right to request a restriction or limitation on the ways your health record information is used. We are not required to agree to your request. If we agree, we will comply with your request, with the exception of emergency care. Specific request must be made in writing.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain way or not at a certain location. Request must be made in writing to this provider.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask for a copy any time.

Other uses of Medical Information: Other disclosures and uses of your information will be made only with your written permission. You may revoke that permission, in writing, any time. This provider will be unable to take back any disclosures we have already made with your permission, and we are required to retain our records of the care that was provided to you.

Changes to this Notice: We reserve the right to change this notice. Upon your request, we will provide you with any revisions.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with this provider or with the U.S. Department of Health & Human Services. All complaints must be submitted in writing.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, have received a copy of Notice of Privacy Practices from Mollie Van Deusen, LPC.
(Print your name)

_____

Signature Date

Professional Disclosure Statement

Qualifications: I am a graduate from Texas Woman's University with a Master of Science and Family Therapy. I am also licensed by the State of Texas as a Licensed Professional Counselor (LPC). My formal education, internships, and practicum experiences have prepared me to counsel individual adults, groups, couples, parents, children, adolescents and families.

Experience: In order to obtain my degree and licensure I completed the hours and testing according to the Texas Family Code and licensing board. See our website (www.SeeMeTherapy.com) for more detailed information on my experience.

Counseling Relationship: Unless you prefer otherwise, I will call you by your first name. Please call me Mollie. Please do not ask me to write a reference for you, or ask me to relate to you in a way other than the professional context of our counseling relationship. You will benefit the most if our interactions address your concerns exclusively. I conduct all counseling sessions in English or with a translator for whom you arrange and pay. I do not discriminate on the basis of race, gender, religion, national origin, disability, or sexual orientation. If significant differences, such as in culture or belief system, exist between us, I will work to understand those differences.

Effects of Counseling: At any time, you may initiate with me a discussion of possible positive or negative effects of entering or not entering into, continuing, or discontinuing counseling. I expect you to benefit from counseling. However, I cannot guarantee any specific results. Counseling is a personal exploration that may lead to major changes in your life perspectives and decisions. These changes may effect significant relationships, your job, and/or your understanding of yourself. You may feel troubled, usually only temporarily, by some of the things you learn bout yourself or some of the changes you made. In addition, counseling can, at times, result in long last effects. For example, one risk of couple counseling is the possibility that the marriage may end. Although the exact nature of changes resulting from counseling cannot be predicted, I intend to work with you to achieve the best possible results for you.

Client Rights: Some clients achieve their goals in only a few counseling sessions, whereas others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time. If you choose to end the counseling relationship, I ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might be harmful. I render counseling services in a professional manner consistent with accepted ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know. I am not able to resolve your concerns, you may report your complaints in writing to the Texas State Board of Examiners of Professional Counselors Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369.

Confidentiality: I will strive to maintain confidentiality at all times during our relationship. Certain conditions may require me to break confidentiality with you, these are; harm to self, harm to others, harm to a child or elder under your care, or intent to harm me in any way. Additionally, certain breaches of confidentiality occur naturally in the counseling experience. Examples of these natural occurrences are; someone sees you in the waiting room, or while entering or leaving my offices someone sees you. Also, as a matter of safety and accountability (especially when working with children), I may meet in an office with some degree of transparency (e.g. cracked door, or see-through or frosted window in a door). Others may be able to identify you by due to this transparency. I cannot prevent other clients, or individuals from looking into or interrupting our session.

Records: Files are closed once the counseling relationship ends. Records for adult clients are destroyed seven years after the file is closed. Records for minor clients are destroyed seven years after the client turns 18 years of age.

Conditions of Ongoing Counseling: While you are in counseling with me, you agree not to maintain or establish a professional relationship with another mental health professional unless you first discuss it with me and sign a release that enables me to communicate with the other mental health professional(s). If you decide to maintain or establish a professional relationship with another mental health professional against my advice, I may consider this your decision to change counselors, and I reserve the right to terminate your counseling.

Referrals: I realize that not all conditions presented by clients are appropriate for treatment at this facility. For this reason, you and/or I may believe that a referral is needed. In that case, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternative to counseling will also be made available upon request. You will be responsible for contacting and evaluation those referrals and/or alternatives.

_____

Client Signature Date

_____

Counselor's Signature Date

Medical and Health History

List any allergies you have: _____ None:_____

Primary Care Physician: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Primary Care Physician's phone number: _____

Date of your most recent physical exam: _____

Please list all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

List all therapists you have seen in the past 5 years, diagnosis received, dates you saw them, and contact information:

_____

_____

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates:

_____

_____

Please indicate which of these substances you currently use:

Substance	Amount Used	How Often
Cigarettes		
Alcohol		
Pills not prescribed for me		
Marijuana		
Cocaine or Crack		
LSD		
Heroin		
Other (please list):		

Please list all current or past health problems, and any major operations:

Current	**Past**

Please indicate if you are having any of the following problems, or if you had them in the past:

	I have this now	**I had this in the past**
Difficulty falling asleep or staying asleep		
Sleeping too much		
Change in appetite, weight loss, or weight gain		
Frequent crying		
Panic attacks or anxiety attacks		
Thoughts of killing or hurting myself		
Attempts to kill or hurt myself		
Problems concentrating		
Problems remembering things		
Periods of daily sadness lasting more than two weeks		
I startle easily		
Can’t stop remembering upsetting past events		
Difficulty controlling my temper		
I physically hurt other people		
I break things sometimes		
I worry a lot		
Little or no interest in sex		
I feel tired almost every day		
Feelings of unreality		
Made myself throw up in order to lose weight		
Use laxative or exercised excessively to lose weight		
I often feel like I am an outsider		
Sexual problems		
Worry that something is wrong with my body		
Frequent arguments with people I live with		
I hear voices inside my head		
I cause physical injury to myself		

Please take your time and describe what brings you to counseling.

MANAGED CARE INSURANCE INFORMATION

Please complete this form if you will be using your insurance, otherwise disregard.

Name of Insured:_____

Is insured a patient? Yes No

Insured's birth date:_____SS#_____

Insured's insurance plan number:_____ Group#_____

Insured's Address:_____

Insured's employer name:_____

Patient's relationship to insured: Self Spouse Child Other

Insurance plan phone number:_____

Insurance plan name and address:_____

Authorization to Release Information to Process Claims:

I hereby authorize direct payment of mental health benefits be made to Mollie Van Deusen for services rendered through this office. I understand that I may be financially responsible for any balance not covered by my insurance. I also authorize Mollie Van Deusen to release any information that may be necessary in processing claims.

_____ _____

Signature of patient, parent, or guardian Date