916-750-5295
centerforhopecounseling@gmail.com

Client Intake Form/HIPPA/Informed Consent

General Information

(**Note**: Due to this information's personal nature, you may leave blank uncomfortable areas)

Name_____ Spouse_____

Address_____

Phone Number (H)_____(W)_____(C)_____

Email Address_____

Preferred Method of Contact: Text_____ Email_____ Which Phone #_____

May we send a text? Yes_____ No_____ a Voicemail? Yes_____ No_____ (see pg. 16)

Date of Birth _____/_____/_____ Emergency Contact _____

Place of Employment_____How long have you been employed here?_____

Position/Title_____How many jobs have you had in the past 5 years?____

Relationship Status: Married_____Single_____Separated_____Living together_____

How long?_____How many previous marriages?_____

If married, what is your perception of your current marriage? (Problems, Communication, etc)

_____

_____

Family Members (List children, parents, grandparents and anyone you currently live with)

Name Age Sex Relationship to you

_____

_____

_____

Have you (or your partner) ever been to counseling? Yes____ No_____ if yes,

With whom? _____When?_____How long?_____

MEDICAL AND MENTAL HEALTH

Please list all medical and mental health providers for the last five years

DOCTOR/CLINIC COMPLETE ADDRESS PHONE

_____

_____

_____

Current medical problem (s)_____

Do the above interfere with your social/occupational functioning? if yes, how?

_____

Are you currently under a physician's care for physical problems?_____Name of Primary

Care Physician_____Number_____Date of last medical exam_____

Current Psychiatric Problem (s) _____

Does it interfere with your social/occupational functioning? if yes,
explain_____

Were you ever hospitalized for a psychiatric illness? Yes_____ No_____ if yes,

Date:_____Name of Hospital and attending Physician_____

PRESCRIPTION MEDICATION

Please list all medication, vitamins & supplements you are currently taking:

Medication	**Amount (mg)**	**For what condition**

PYSCHO/SOCIAL HISTORY

SexualOriental: Heterosexual____Lesbian_____Gay____Bisexual_____Transgender_____

Are you currently sexually active? yes_____ no_____ Describe any problems in your sexual relationship_____

Abuse

Have you ever been a victim of physical and/or sexual abuse? Yes_____ No_____ if yes, explain_____

#of perpetrators_____ age of onset_____ age abuse ended_____

Relationship to perpetrator_____ Are you currently in an abusive relationship? Yes_____ No_____ Are you the abuser or the victim?_____

Were these issues ever discussed in therapy? Yes_____ No_____

Please list hobbies, social/educational organizations

_____

Do you have a best friend? Yes____ No_____ how often do you talk?_____How often do you see each other?_____

Education

Highest grade completed_____Degree/certificate_____

Name of School/University_____Are you Currently enrolled?_____

FAMILY HISTORY

	1ST NAME	AGE	MENTAL ILLNESS	LIVING	DRUG/ ALCOHOL ABUSE	SUICIDE ATTEMPT
Self (client)						
Spouse						
Father						
Mother						
Siblings						
Children						

List other relatives with mental illness and/or substance abuse histories:

_____

Do you wish to talk about religion/spiritual issues in therapy? Yes_____ No_____

If yes, what is your religious affiliation?_____

List the reason (s) you are seeking therapy:

_____

_____

What problem (s) are you currently experiencing **(please circle all that apply)**

Mental illness	Grief & Loss	Job issues	Separation/Divorce
Other relational issues	Issues of the past	Financial issues	Depression/anxiety
Trauma	Domestic Abuse	Health/Medical issues	Mood swings
Anger	Addiction	Drug/Alcohol	Parent/Child issues
ADHD symptoms	Sexual Dysfunction	Self-injury	Issues with eating

Others:

_____

_____

_____

How have these problems affected your daily functioning? **Circle all that apply**

Change in sleep patterns	Depressed mood	Anger problems	Job performance
Relational Issues	Anxiety/worry/panic	Legal Issues	Mood swings
Thoughts of death/suicide	Decreased Motivation	Change in appetite	Finances
Decreased interest or pleasure	Overall Health	Sexual Dysfunction	
Decreased Concentration	School/Education	Social Functioning	

Others, Explain_____

_____

What specific changes do you intend to make during the process and outcome of our sessions?

_____

_____

Please list any other relevant information you think I should know:

INFORMATION AND CONSENT

Thank you for selecting me as your therapist. This document informs you about my background and ensures that you understand our professional relationship.

The Texas Board of Examiners of Professional Counselors (TSBEPC) licensed me. I have worked with children, adolescents, and adults in individual, couple, family, and group situations. I hold a Master of Divinity from Andrews Theological Seminary and a Master of Professional Counseling from Grand Canyon University. My license # is **75305.** I define therapy, counseling, or psychotherapy, which literally means souls guiding, as a helpful, constructive dialogue between a practitioner/guide (with special training) and one or more client (s). As your guide, I hope to create a dialogue with you that will promote your specific goals and your overall health. As for you, I only accept clients who I believe have the capacity to resolve their own troubling experiences with my assistance.

I will keep confidential anything you say to me, with the following exceptions: (a) you allow me to tell someone else by signing a release of information form; (b) I determine you are an imminent danger to yourself and/or others; (c) I am ordered by a judge, magistrate, and/or master of the court to disclose your information; and/or you report past and/or present actions of a physically/sexually abusive nature against a minor and/or adult who is unable to defend her/himself in a common manner (e.g. certain older, disabled and/or otherwise physically or mentally challenged persons). Dependent upon circumstances, I reserve the right to disclose information to other family members if this disclosure seems necessary for therapy to proceed profitably. Examples of these circumstances include, but are not limited to, a minor who tells me s/he is involved in dangerous activity or an adult who tells me s/he has contracted HIV.

_____Initials

Other possible exceptions to confidentiality include (a) your status as a minor (b) your parent/guardian paying for your sessions and requesting information; your death; (d) my consultation with legal, mental health, and/or supervisor professionals; (e) my audio and/or video taping our sessions; and (f) when working with couples, I do not keep significant information private from either partner. As a final protection of your confidentiality, if we ever accidentally see each other in public, I will not verbally acknowledge you unless you first acknowledge me.

Treating Minor Children: Under Texas law, permission to treat minors of divorced parents must be given by the Managing Conservator, or the parent that is specifically authorized by a court order to do so. Therefore, I may ask for a copy of a decree of guardianship or power-of-attorney.

If at any time for any reason you are dissatisfied with my services, please let me know. If we are not able to resolve your concerns, you may send written concerns to 1100 W. 49th Street, Austin, Texas, 78756-3138. Additionally, you may call the ACA at (800) 838-9808. If you ever experience something you identify as life-threatening emergency, including your unwavering commitment to kill yourself and/or someone else, please call 911.

I assure you that my services will be rendered in a professional manner consistent with the accepted ethical standards. Sessions are **50 -60 minutes** in duration. Please note that it is impossible to guarantee any specific results regarding therapy wants. Current research reveals that some people improve from therapy, some remain unchanged, and some distress. However, together we will create a therapeutic experience the best possible results for you.

Please keep in mind that I do not prescribe medication nor perform any medical procedures

_____**Initials**

FEE SCHEDULE

In return for fees of $120 per individual session, and $150 per couple/family session. I agree to provide therapy services to you. If these fees should increase, I will give you at least a one-month notice to accommodate the change. Generally, I do not have a sliding scale for my fees; however, I occasionally negotiate such fees in special circumstances and upon request. The fee for each session will be due and must be paid with cash, check, or credit card at the conclusion of each session. If the fee is not paid, I reserve the right to involve a third party, who will be given the required information in order to secure the fee collection. Upon your request, I will provide a per-session or month receipt for all fees paid. In the event that you will not be able to keep an appointment, **you must notify me 24 hours in advance by calling 916-750-5295**. If I do not receive such advance notice or you no-show, you will be responsible for the fees outlined in the cancellation policy for session that you missed, as your absence prevented me from receiving payment from other (waiting-list) clients. Any time a legal authority requires me to act on the behalf of you and/or others associated with you, I charge for such action (i.e., a fee of $120 an hour for all necessary consultation, research, driving deposition, courtroom, etc, time). Additionally, my above session fees apply to phone conversations and email exchanges occurring as a result of your initiative (i.e. your contacting me or my returning your contact) and exceeding 10 minutes.

ONLY FOR CLIENTS ACCESSING THIRD PARTY REIMBURSEMENT

(Note: Involving a third-party reduces confidentiality)

If you want to use your health insurance to cover my services, we often must preauthorize such coverage prior to any meeting that we have for the insurance company to reimburse me. Please note that if your health insurance company does not reimburse me despite my standardized attempts to receive payment, you are ultimately responsible for paying me $75 (or the company's agreed upon rate with me, whichever is higher) a session. Some health insurances companies will reimburse clients for my therapy services and some will not. Those that do reimburse usually require you pay a co-payment before reimbursement is allowed, and then usually only a percentage of my fees are reimbursable. Because of the reduced fee they pay me, I allow very few insurance clients into my practice. As noted above, in the event that you will not be able to keep an appointment, **you must notify me 24 hours in advance. If I do not receive such advance.** If I do not receive such advance notice or you no-show, **you will be responsible for the appointment that you missed.**

_____Initials

Please keep in mind that using your health insurance to pay for my services has many disadvantages: (a) you automatically reduce your confidentiality; (b) your length of services is determined by the insurance company representative, not by you or me; (c) your quality of services, due to in-session time used to authorize sessions and complete paperwork, is influenced by requirements made by the insurance company not by me; (d) insurance companies require that I diagnose you and indicate that you have an "illness" from the Diagnostic and Statistical Manual of Mental Disorders (IV-TR Edition) before they will agree to reimburse me. Considering the fact that this diagnosis becomes part of your permanent insurance records and that such records can influence decisions made about potentially significant events in your life, I encourage clients to reconsider their choice of using their insurance companies to reimburse for my services. In the event a diagnosis is required, I will inform you of the diagnosis I plan to render before I submit it to the health insurance company.

If you have any questions, please feel free to ask me. By signing this, you affirm that you have read, understood, and will abide by all legally-binding stipulations contained in this document.

_____ _____

Print Name Date

Signature_____

_____ _____

Print Name Date

Signature_____

_____ _____

Name of minor (if applicable) Date of Birth

Notice of Privacy Practices

UNDERSTANDING YOUR HEALTH INFORMATION

Each time you contact Deidra-Ann Leiba, LPC-i, M.Div, a hospital, clinic, or any other "healthcare provider" information is collected about you and your mental or physical health. The information is collected is called, according to the law, P**rotected Health Information (PHI).** This information is maintained in files and stored in my office.

I am required by law to inform you on the Health Insurance Portability Accountability Act of 1996 (HIPAA) and how it relates to PHI. HIPAA requires me to keep your PHI private and to give you this notice of my legal duties and my privacy practices which is called the **Notice of Privacy Practices.** This information describes how PHI may be used and disclosed.

YOUR PHI COULD INCLUDE:

- Reasons you came for services, complaints, needs, strengths
- Personal information including your address, phone numbers and work place
- A treatment plan for resolving the issues that brought you to me
- Progress notes which record the progress you are making towards a resolution
- Information concerning current and past prescribed medications
- History of previous interventions
- Records I may receive from others including psychological and psychiatric evaluations, school records such as grades, attendance, ARD information and diagnostic records.

YOUR PHI COULD BE USED FOR:

- To help assign a treatment plan
- To create a strategy for problem resolution
- To provide information to others (with or without your authorization)

USES AND DISCLOSURES OF HEALTH INFORMATION WITH AUTHORIZATION

- **BUSINESS ASSOCIATES/REFERRAL -**With a signed Authorization from you I may call referral or business associates on your behalf such as psychiatrists, school counselors, and other community agencies.

- Any other uses or disclosures of your PHI not addressed in this Notice or Privacy Practices or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time.

_____Initials

USES AND DISCLOSURES OF HEALTH INFORMATION WITHOUT AUTHORIZATION

When you request services from certain uses and disclosures of your PHI are necessary and permitted by law in order to best serve you, and to process payment. The following describe ways I may use or disclose your PHI.

- **IMPLEMENT SERVICES/TREATMENT-**I will use the information which I get from you or from others mainly to provide you with the best possible services, treatment and interventions.
- **HEALTH CARE OPERATIONS-**I may use or disclose your PHI for what is known as health care operations, some examples would be:
    - Appointment reminders-I may call or send you a letter to reschedule or remind you of appointments and services.
    - Referrals-I may refer you to other professionals or organizations for services that may be of interest to you.
    - Insurance companies may request information
- **PAYMENT-**To arrange payment for services
- **OTHER CARE OPERATIONS-**In some situations, I may use and disclose your PHI without your consent or authorization, below are some of those situations:
    - Texas Penal Code 261.101 requires that if I suspect, believe or have knowledge of abuse or neglect of a child/adult. I must notify authorities within 48 hours.
    - If I suspect, believe or have knowledge of you harming yourself or others I will notify the appropriate authorities and persons who have been threatened.
    - If I am served a subpoena or a court order I am required by law to release the requested information.
    - Federal regulations allow disclosures of substance dependency to the parents of a minor when the following conditions are met:

    1. An adolescent has applied for services
    2. I believe that an adolescent, because of an extreme substance use disorder or a medical condition does not have the capacity to decide rationally whether to consent to the notification of his/her guardians.

3. I believe the disclosure is necessary to cope with a substantial threat to the life or well-being of the adolescent or someone else.

YOUR HEALTH INFORMATION RIGHTS

Although your PHI is the property of Deidra-Ann Leiba, LPC-intern, M.Div., you have certain rights to the information they include:

- **Privacy Complaints-**You have the right to file a complaint if you believe your privacy rights have been violated. all complaints must be in writing. Filing a complaint will not change the services I provide to you in anyway. This complaint will be addressed to the Federal Secretary of the Department of Health and Human Services, or the Texas Licensing board of Professional Examiners. **There will be no retaliation for registering a complaint.**
- **Privacy Contact- Y**ou can ask me to communicate with you about your health related issues in a particular way or at a certain place which is more private for you. For example, you can ask me to call you at home and at work to schedule or counseling appointment. I will try my best to do as you request.
- If You have the right to ask me to limit what I tell people involved in your care for the payment for your care spending members and friends. Our agreement except if it is against the law, or in an emergency, or when information is necessary to treat you.
- You have the right to look at the health information and billing records I have about you. You may request a copy of your PHI but I may charge you. (please see below **LIMITATIONS TO YOUR HEALTH INFORMATION RIGHTS** for further clarification.

_____Initials

- You have to make this request in writing and send it to the address above. You must tell me the reasons you want to make the changes.
- You have the rights to a copy of this notice.

LIMITATIONS TO YOUR HEALTH INFORMATION RGHTS

- I reserve the right to deny PHI if access to such information is deemed by me that says disclosure of PHI would cause a threat and/or harm to you or your child.
- perfect rollover 42 U.S.C. 290dd-2 as well a 42 Code of Federal Regulations (C.F.R.) Part 2, I must received a court order or a signed authorization to disclose or use PHI found adolescence before I release information related to substance abuse or PHI about the adolescent. I must receive a court order or Signed Authorization to disclose or Use PHI from the adult before I release information relating to Substance abuse or HIV about the adult. (Please refer to OTHER CARE OPERATIONS) above for further clarification.

_____Initials

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MENAS

I, _____AUTHORIZE Deidra-Ann Leiba, LPC-intern, M.Div

Center For Hope Counseling
Deidra-Ann Leiba, LPC, M.Div,

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

- Information Related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Completed forms, including forms that may contain sensitive, confidential information
- Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
- My health records, in part or in whole, or summaries of material from my health record
- Other information. Describe:_____

BY THE FOLLOWING NON-SECURE MEDIA:

- Unsecured email.
- SMS text message (I.E. traditional text messaging) or other type of "Text message."
- Other media. Describe:

_____

TERMINATION

- This authorization will terminate_____days after the date listed below.

OR

- This authorization will terminate when the following event occurs:

_____.

I have been informed of the risks, including but not limited to my confidentiality and treatment, of transmitting my protected health information by unsecured means. I understand that I am not

required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

_____ _____

Name of Child/Adolescent Parent or Guardian's Signature Date

CANCELLATION POLICY

You set an appointment with the therapist, that time is reserved just for you. You are responsible for attending each session. However, I understand that, in certain circumstances, unexpected things can arise which prevent individuals from being able to keep a scheduled appointment.

Therefore, I will adhere to the following policy: if I am prevented from keeping appointment due to sickness, emergency, etc., I will notify you as soon as possible. Similarly, if you are prevented from keeping schedule appointment, I ask that you notify me at least 24 hours in advance or atlas 9 a.m. morning of appointment. This notice offers me time to get the appointment to another client that may be on the waiting list. If I do not receive 24 hour advance or by 9 a.m. the morning of the appointment, you will be responsible for paying a $25 cancellation fee.

I understand the cancellation policy and agree to give 24 hour notice for any cancellations. I further agree to pay $30 for any appointments I miss, or did not cancel according to the policy outlined above.

_____

Name

_____

Signature and Date