INTAKE FORM

#  Melissa Friesenhahn, MA, LPC

 **~ Licensed Professional Counselor~**

 Date:

**Black Ink Only**

This form will help your counselor understand more about you and will be part of your case file.

Last Name: First Name: MI:

Birth Date: Age: Gender: Male Female Ethnicity\_\_\_\_\_\_\_\_\_

Address:

City State Zip Code

Client SSN# DL#

**Please provide the number that is the best to reach you:**

|  |  |  |
| --- | --- | --- |
| Home Phone:  | Work Phone:  | Cell Phone: |
| May we leave a message or text? Yes No  | May we leave a message or text?  Yes No  | May we leave a message or text?  Yes No  |

Occupation: Employer:

Marital Status: Prior Marriages: \_\_\_\_\_\_\_\_\_\_\_Education:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Last Name: Spouse First Name: Spouse MI:

Occupation: Employer:

Children:

Name Sex Age Relationship to you

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Primary Care Provider: Phone Number: Fax:

Psychiatrist: Phone Number: Fax:

**I would like for the Therapist to communicate with my Primary Care Provider regarding my Treatment: Yes or No**

**I would like for the Therapist to communicate with my Psychiatrist regarding my Treatment: Yes or No**

**INSURANCE INFORMATION**

Insurance Company: Policy Number:

Insurance Telephone Number: Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name/Insured Name:

Insured SSN: Insured Birth date:

Who referred you: Self Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Web Insurance Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Concern:**

|  |
| --- |
| What brought you here today? |

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| --- | --- | --- | --- | --- |
| **Please use the following scale to answer the next three questions:** | 1 | 2 | 3 | 4 |
|  |  | Not at all | Mildly | Moderately | Highly |
| 1. | How serious do you consider your present concern(s)? |

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| 2. | How motivated are you to resolve your concern(s)? |

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| 3. | How optimistic are you that your concern(s) can be resolved? |

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Previous Counseling? Yes / No Counselor: Date:

**Please list your current medications and doses:**

|  |  |
| --- | --- |
| Prescription: | Supplements: |

Please list any Food or Drug Allergies or any adverse reactions you have experienced:

|  |
| --- |
|  |

**Please list any medical problems:**

Medical Conditions Date of Diagnosis

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| --- | --- |
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Prior Hospitalizations:

Suicide Attempts or Self Injury Behaviors:

Age Related Issues (health, employment, disability):

**FAMILY MEDICAL AND MENTAL HEALTH HISTORY**

**Please check any medical and /or mental health conditions that apply to any family members:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Heart Disease/Condition |  | Head Injury or Headaches  |  |  |
|  | High Blood Pressure |  | Seizures |  | Depression |
|  | Heart Attack |  | Thyroid Disease |  | Anxiety or Panic Attacks  |
|  | Stroke  |  | Asthma |  | Bipolar Disorder |
|  | Use or Abuse Alcohol or Drugs  |  | Diabetes |  | Eating Disorders |
|  | Cancer |  | Other Medical Conditions: |  | Other Mental Health Conditions: |
|  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Family History****Continued** | Mother’s Age \_\_\_\_\_\_\_\_\_\_\_\_\_ If deceased, how old were you when she died? \_\_\_\_\_\_\_\_\_\_  |
| Father’s Age \_\_\_\_\_\_\_\_\_\_\_\_\_ If deceased, how old were you when he died? \_\_\_\_\_\_\_\_\_\_ |
| If your parents are separated, how old were you then? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Number of brother(s) \_\_\_\_\_\_\_\_ What are their ages? \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ |
| Number of sister(s) \_\_\_\_\_\_\_\_ What are their ages? \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ |
| If you were adopted or raised with parents other than your natural parents please explain: |
| Briefly describe your mother’s personality:Briefly describe your father’s personality: | Briefly describe your stepparent(s) personality: |
| **Briefly describe your past and current relationships with your:** |
| Mother | Father |
| Stepmother | Stepfather |
| Religious Affiliation |

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| --- |
|  |

 | Jewish  |

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| --- |
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 | Christian/Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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 | Catholic |

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 | None, but I believe in God |
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 | Protestant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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 | Atheist or agnostic |
| Do you desire to have your religious beliefs and values incorporated into the counseling process? (Please check one)  |
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 | Yes |

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 | No |

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 | Not Sure |
| **Please mark all of the following that apply** |
|  **Feelings** | Thoughts |
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 | Helpless |

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 | Anxious/Fearful |

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| --- |
|  |

 | Confused |

|  |
| --- |
|  |

 | Racing |
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| --- |
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 | Depressed/Sad |

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| --- |
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 | Out of Control |

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 | Fragmented |

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 | Obsessive |
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 | Shameful |

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 | Afraid/Scared |

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 | Worthless |

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 | Distracted |
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 | Angry |

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 | Burnt out/worn out |

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 | Unmotivated |

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 | Intrusive Memories |
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 | Guilty/Remorseful |

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 | Relaxed |

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 | Unattractive |

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 | Paranoid |
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 | Hopeless/Hopeful |

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 | Happy/Excited  |

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 | Unlovable |

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 | Worry |
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 | Lonely |

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 | Irritable |

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 | Confident |

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 | Sensitive |
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 | Grieved |

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 | Empty/ Numb |

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 | Worthwhile |

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 | Distrust |
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 | Stressed |

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 | Insecure |

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 | **Suicidal or Homicidal**  |

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 | Positive |
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 | Unhappy/Unfulfilled |

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 | Mood Swings |  |
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 | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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 | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Symptoms/Behaviors |
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 | Eating More or Less |

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 | **Acting Out Sexually** |

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 | Financial Difficulties |
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 | Procrastinating |

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 | Acting Aggressively |

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 | Legal Problems |
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 | Impulsivity |

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 | Phobia/Panic Attacks |

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 | Parent/Child Conflicts |
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 | Irritability |

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 | Post Traumatic Stress Disorder |

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 | Marital Problems |
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 | Crying |

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 | Attention Deficit Disorder/ADHD |

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 | Relationship Concerns |
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 | Passivity |

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 | Chronic Pain  |

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 | Withdrawal from Family/Friends |
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 | Acting Compulsively |

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 | Prior Substance Abuse Treatment |

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 | Job Problems |
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 | Poor Self-Image |

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 | **Legal/Illegal Drug Use** |

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 | Spiritual Issues |
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 | Poor Concentration/Memory |

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 | **Alcohol Use/Abuse** |

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 | **Victim or Perpetrator of Abuse**  |
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 | Injuring Self  |

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 | **Tobacco Use** |

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 | Seeing/Hearing things others don’t |
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 | Sexual Concerns  |

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 | **Sex Addiction**  |

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 | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  **Physical Symptoms** |  |
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 | Insomnia | **Family History of Mental Health Issues:** Mothers Family History:  Fathers Family History:  |
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 | Tired/ Easily Fatigued |
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 | Restlessness/Tense |
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 | Rapid Speech |
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 | Headaches |
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 | Tightness In Chest |
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 | Dizziness or Light-headedness |
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 | Numbness or Tingling | **Cultural Considerations:** **Please share anything else that might be helpful for your counselor to know:** |
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 | Pain |
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 | Rapid Heart Beat |
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 | Weight Gain or Loss |
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 | Excessive Sleep |
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 | Loss of Memory |
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 | Eating Problems |
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 | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Who may we contact in an emegerency?­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client:

I authorize Melissa Friesenhahn to use my health information to activate my insurance benefit program. The purpose will be to process claims for insurance payment. I also understand my privacy will be respected and procedures will follow the HIPAA Privacy Notice that I have received.

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

Client Signature Date

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

Parent/Guardian Signature (if client is under 18) Date

 **Child/Adolescent Developmental History**

***(for ages 17 and younger)***

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **What was your child’s birth weight?**\_\_\_\_\_\_\_\_ lbs. \_\_\_\_\_\_\_\_ oz. Unknown**Was delivery normal?**Yes UnknownNo; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Did the birth mother experience any physical or emotional problems during pregnancy?**Yes; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unknown**Were medications taken during pregnancy?**Yes; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unknown**Did the birth mother consume alcoholic beverages or abuse any street drugs during pregnancy?**Yes; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unknown**Did the baby experience any problems immediately after birth?**Yes; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unknown**Has your child ever required hospitalization?**Yes; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unknown**Is there any history of physical, sexual or emotional abuse?**Yes; specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unknown**Is there a history of prolonged separations or traumatic events?**Yes; specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unknown | **At what age did your child do the following?***(Italicized areas reflect normal development)****\_\_\_\_\_\_\_\_*** smiled *(6 mths)*\_\_\_\_\_\_\_\_sat alone *(6 to 10 mths)*\_\_\_\_\_\_\_\_ talked in sentences *(30 to 36 mths*)\_\_\_\_\_\_\_\_ walked by self *(12 mths)*\_\_\_\_\_\_\_\_ held head up (*3 to 4 mths)*\_\_\_\_\_\_\_\_ fed self *(2yrs)*\_\_\_\_\_\_\_\_ crawled *(6 to 10 mths)*\_\_\_\_\_\_\_\_ rode a bike *(6 yrs)*\_\_\_\_\_\_\_\_ rolled over *(6 mths)*\_\_\_\_\_\_\_\_ talked in single words *(18 to 24 mths*)\_\_\_\_\_\_\_\_ pulled up *(6 to 10 mths)*\_\_\_\_\_\_\_\_ established toilet training *(2 ½ to 4 yrs)***How would you describe your child’s approach to new situations?**Positive, jumps right inWithdrawn, tends not to participateSlow to warm up; cautious**How would you generally describe your child’s overall mood?**Positive (happy, laughing, upbeat, hopeful)Negative (depressed, cranky, angry, hostile)Mixed but more positive, than negativeMixed but more negative than positive**Which school is your child currently attending?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Is your child currently receiving special services in this school?**Yes; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No**Has your child ever failed a class or been held back for academic reasons?**Yes; specify grade: \_\_\_\_No**Is your child expected to pass this school year?**YesNo |

# **Melissa Friesenhahn MA, LPC**

 **Licensed Professional Counselor, LPC**

### OUTPATIENT SERVICES CONTRACT

# **COUNSELING SERVICES**

Welcome to my practice. This document contains important information about professional services and business policies. Please read it carefully and jot down any questions you have so they can be discussed. When you sign this document, it will represent an agreement between us.

Counseling is not easily described in general statements but depends on the counselor, client and the particular problems presented. Counseling calls for an interaction between therapist and client and for therapy to be successful, clients are to employ concepts, strategies and techniques discussed during sessions. Therapy can have some unpleasant aspects that may be coupled with uncomfortable feelings. However, these experiences often lead to improved relationships, solutions to problems, and a reduction in feelings of distress.

# **COUNSELING SESSIONS**

Issues and concerns are evaluated during the first session and continue throughout the therapeutic process. During this time, it can be determined if the client/therapist relationship will be able to generate the desired treatment goals. Counseling sessions are 45-60 minutes and begin on a weekly or bi-weekly schedule and are then scheduled less frequently based on progress. The client is responsible for scheduling their sessions and canceling them if they are unable to attend. **We request a twenty-four hours notice or a $100.00 fee will be assessed for the missed session. A $120.00 fee will be assessed for any session missed without notification.** This fee cannot be billed to your insurance and must be paid out of pocket at the next session. The office answering machine is on 24 hours a day for your convenience.

# **PROFESSIONAL FEES AND BILLING SERVICES**

The fee for the initial therapy session which includes the initial evaluation and initial treatment planning is $165.00. Subsequent **individual, couple, or family therapy sessions are** **$130.00 - $155.00.** Unfortunately, since most insurance companies do not consider couple’s therapy as medically necessary, each session will be billed at the private pay rate, which ranges from $130 - $165. Payment is expected from the client at the time of service or from the insurance company. **Insurance only covers what is medically necessary.** You are responsible for any fees insurance does not cover. Other professional services such as preparation of documents or treatment summaries will be billed at the same rate.

**PLEASE NOTE: The therapist does not participate in legal proceedings but will refer the client to another clinician or entity that deals with legal issues. Please discuss this with the therapist if the need arises.**

# **CONTACTING ME**

The office telephone is answered from 10:00 AM and 6:00 PM, Monday thru Thursday, and voicemail is available 24 hours a day. The therapist is usually in session and not available by telephone. Please leave a message on the voice mail. Every effort will be made to return all calls as soon as possible. In the case of an urgent need or emergency the client is encouraged to call 911 or go the nearest emergency room.

## PROFESSIONAL RECORDS

The laws and standards for counseling in Texas require the therapist to keep treatment records. These records are confidential and will not be released to anyone without the client’s consent. Please be aware that the client may choose not to release these records if they can be emotionally or legally damaging. The therapist will make these records available to another mental or medical health professional at the client’s request.

## MINORS

The therapist is committed to providing confidentiality for adolescent clients. The therapist will provide generalized (not specific) information about the therapy sessions to the parents/guardians of the client. The therapist will provide more specific information as approved by the adolescent client. Parents of children in therapy are involved in the process and participate in formulating the treatment goals.

PLEASE NOTE: The therapist will ask for help from a parent or guardian if the client is at risk of seriously harming him/her self or someone else. There are also other situations that may require the therapist to release the records of minors.

## CONFIDENTIALITY

The privacy of all communications between a client and therapist is protected by law, and the therapist can only release information about their work with the client’s written permission. However, there are exceptions:

* The therapist is legally obligated to take action to protect a child, elderly person or disabled person from abuse by reporting the action to the appropriate state agency.
* The therapist will contact family members or others if there is a threat of serious self harm or harm to another. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. In these cases, a more intensive treatment plan will be developed by the therapist, the client and their family members.
* The therapist is legally obligated to release the client’s therapy notes (or a summation) if requested by a court of law.

On occasion the therapist may need to consult with other professionals about a case. During these consultations, cases are discussed without revealing the identity of the client. The consultant is also legally bound to keep all information confidential.

Questions or concerns about confidentiality can be discussed with the therapist

**FEDERAL HEALTH INSURANCE PORTABLITIY AND ACCOUNTABILITY ACT (HIPAA)**

This law insures the confidentiality of all electronic transmission of information about the client. Whenever the therapist transmits information about the client electronically (i.e. sending bills or faxing information), it will be done with special safeguards to insure confidentiality. If the client elects to communicate with the therapist by email or text, please be aware that email or text is not completely confidential. Any email the therapist receives from the client and any responses sent, will be printed out and kept in the client’s treatment record.

Your signature indicates that you have read this document and consent to treatment. This will serve as a contract between you and the provider:

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

Client Signature Date

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

Client Printed Name Date

If client is under 18, parent/guardian consent is needed.

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

Parent/Guardian Signature Date

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

Parent/Guardian Printed Name Date

 **Coordination of Care between Health Care Providers / Release of Information**

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. **This form will allow your behavioral health provider to share protected health information (PHI) with your other provider or person you designate below**. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

**Patient Rights**

• You may end this authorization (permission to use or disclose information) any time by contacting the practitioner’s office.

• If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.

• You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.

• You have a right to a copy of this signed authorization.

• If you choose not to agree with this request, your benefits or services will not be affected.

**Patient Authorization**

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

\_\_Melissa Friesenhahn M.A., LPC is authorized to release protected health information related to the

(Provider Name-Please Print)

evaluation and treatment of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_\_.

(Member Name) (Date of Birth – MM/DD/YYYY)

PCP Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP Phone/Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCP Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BH Provider/Psychiatrist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BH Provider Phone/Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BH Provider Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Other Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Phone/Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

(Signature of Patient, Parent, Guardian or Authorized Representative) (Date)

If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)

\_\_\_ **I hereby *refuse* to give authorization for any release of information**

**CREDIT CARD AUTHORIZATION FORM**

**Alamo Counseling is authorized to maintain credit card payment information in our confidential files. This form is provided for you to supply Alamo Counseling this information. Your signature, below, authorizes us to review this information and deduct fees from the credit card below in the case of a cancellation less than 24 hours, or in the case of a session missed without notification, co-pays due, and past due amounts.**

**We accept all major credit cards at this time.**

**A Health Savings account (HSA) or employee paid benefits account card may not be used for cancellation fees.**

|  |
| --- |
| CARD INFORMATIONCard Type: Visa MasterCard Discover Other \_\_\_\_\_\_\_\_\_Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_ CVV Code (on back): \_\_\_\_\_\_\_\_\_\_\_Billing Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_Cardholder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **If anyone other than the cardholder is authorized to use this credit card, please have him or her print and sign his or her name:**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cardholder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**I understand that my card will be charged on the day of my scheduled appointment if I cancel last minute (less than 24hrs before) or no show (missed without notification I understand my card will be charged $100.00 for a cancellation, $120.00 for a no show, co-pays due, and past due amounts.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alamo Counseling, LLC

Melissa Friesenhahn MA, LPC

**INFORMATION, AUTHORIZATION, &**

**CONSENT TO TECHNOLOGY-ASSISTED SERVICES**

This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to Technology-Assisted Services. Technology-Assisted Services is defined as follows:

“Technology-Assisted Services means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. Technology-Assisted Services facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers.”

Technology-Assisted Services is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Protected Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of Technology-Assisted Services in order to provide you with the highest level of care. Therefore, I have completed specialized training in Technology-Assisted Services. I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

**The Different Forms of Technology-Assisted Media Explained**

**Telephone via Landline**:

It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided me with that phone number, I may contact you on this line from my own landline or from my cell phone, typically only regarding setting up an appointment if needed. If this is not an acceptable way to contact you, please let me know. Telephone conversations (other than just setting up appointments) are billed at my hourly rate.

**Cell phones**:

In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you, typically only regarding setting up an appointment if needed. Telephone conversations (other than just setting up appointments) are billed at my hourly rate. Additionally, I keep your phone number in my cell phone which is password protected. If this is a problem, please let me know, and we will discuss our options.

**Text Messaging:**

Text messaging is not a secure means of communication and may compromise your confidentiality.

Furthermore, sometimes people misinterpret the meaning of a text message and/or the emotion behind it.

However, I realize that many people prefer to text because it is a quick way to convey information. Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations. Please do not bring up any therapeutic content via text to prevent compromising your confidentiality.

**Email:**

Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations. Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.

I also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this to me via email because I may not see it in a timely matter. Instead, please see below under "Emergency Procedures."

**Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc.:**

It is my policy not to accept "friend" or "connection" requests from any current or former client on my personal social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of our relationship. Please refrain from making contact with me using social media messaging. These methods have insufficient security, and I do not watch them closely. I would not want to miss an important message from you.

In the event you follow one of the social media accounts, you are comfortable with the general public being aware of the fact that your name may be attached to this account.

Please refrain from making contact with me using social media messaging systems such as Facebook Messenger. These methods have insufficient security, and I do not watch them closely. I would not want to miss an important message from you.

**Video Conferencing (VC):**

Video Conferencing is an option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. I utilize DoxyMe This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that DoxyMe is willing to attest to HIPAA compliance and assumes responsibility for keeping our VC interaction secure and confidential. If we choose to utilize this technology, I will give you detailed directions regarding how to log-in securely. I also ask that you please sign on to the platform at least five minutes prior to your session time to ensure we get started promptly. Additionally, you are responsible for initiating the connection with me at the time of your appointment.

I strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

**Recommendations to Websites or Applications (Apps):**

During the course of our treatment, I may recommend that you visit certain websites for pertinent information or self-help. I may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment.

**Electronic Transfer of PHI for Billing Purposes:**

If I am credentialed with and a provider for your insurance, please know that I utilize a billing service that has access to your PHI. Your PHI will be securely transferred electronically.

**Electronic Transfer of PHI for Certain Credit Card Transactions:**

I utilize Square as the company that processes your credit card information This company may send the credit card-holder a text or an email receipt indicating that you used that credit card for my services, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit card-holder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill. The name on the charge will appear as Alamo Counseling, LLC

**Your Responsibilities for Confidentiality & Technology-Assisted Services**

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any Technology-Assisted Services sessions.

**In Case of Technology Failure**

During a Technology-Assisted Services session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone/cell. Please make sure you have a phone with you, and I have that phone number. If we get disconnected from a video conferencing or chat session, end and restart the session. If we are unable to reconnect within ten minutes, please call me.

If we are on a phone session and we get disconnected, please call me back or contact me to schedule another session. If the issue is due to my phone service, and we are not able to reconnect, I will not charge you for that session.

**Cost of Sessions**

I may provide phone, and/or video conferencing if your treatment needs determine that Technology-Assisted Services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, Technology-Assisted Services, or both. We will discuss what is best for you.

Technology-Assisted Services sessions fees are $130.00-$165.00 per 45-53 minute session. I require a credit card ahead of time for Technology-Assisted Services therapy for ease of billing. Your credit card will be charged at the conclusion of each Technology-Assisted Services interaction. This includes any therapeutic interaction other than setting up appointments. Visa, MasterCard, Discover, or American Express are acceptable for payment

Insurance companies have many rules and requirements specific to certain benefit plans. At the present time, many do not cover Technology-Assisted Services. Unless otherwise negotiated, it is your responsibility to find out your insurance company’s policies and to file for insurance reimbursement for Technology-Assisted Services. As stated above, I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

You are also responsible for the cost of any technology you may use at your own location. This includes your computer, cell phone, tablet, internet or phone charges, software, headset, etc.

**Cancellation Policy**

In the event that you are unable to keep either a face-to-face appointment or a Technology-Assisted Services appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

**Limitations of Technology-Assisted Services Therapy Services**

Technology-Assisted Services should not be viewed as a complete substitute for therapy conducted in an office. It is an alternative form of therapy or adjunct therapy, and it involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see a tear in your eye. Or, if audio quality is lacking, I might not hear the crack in your voice.

There may also be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction.

I will require you to show a valid picture ID and another form of identity verification such a credit card in your name. At this time, you will also choose a password, phrase, or number which you will use to identify yourself in all future sessions. This procedure prevents another person from posing as you.

**Communication Response Time**

I am set up to accommodate individuals who are reasonably safe and resourceful. My office is not an emergency facility and I am not available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

**In Case of an Emergency**

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

* Call 911
* Go to the emergency room of your choice
* Contact your health insurance provider for an emergency referral

**Emergency Procedures Specific to Technology-Assisted Services**

There are additional procedures that we need to have in place specific to Technology-Assisted Services. These are for your safety in case of an emergency and are as follows:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Technology-Assisted Services are not appropriate.

**I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only.** Please write this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine it necessary, the ECP agrees take you to a hospital. By your signature below, you expressly authorize me to contact the designated person if I believe that there is an emergency and/or if I believe that you are a danger to yourself or others. Please list your ECP here:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**You agree to inform me of the address where you are at the beginning of every Technology-Assisted Services session.**

**You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a Technology-Assisted Services session). Please list this hospital and contact number here:**

Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Technology-Assisted Services**

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Your signature below indicates that you have read this document (INFORMATION, AUTHORIZATION, & CONSENT TO TECHNOLOGY-ASSISTED SERVICES), and agree to its terms, and you are authorizing me to utilize the Technology-Assisted Services methods discussed. I also understand during all Technology-Assisted Services I must be physically located within the state of Texas.

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

Client Name (Please Print)

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

Date

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

Client Signature

Parent’s or Legal Guardian’s Name (Please Print)

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

Date

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

Signature of parent or guardian for clients younger than 18 years old