CASE COUNSELING, PLLC

Individual Intake Form

Hello and Welcome to Case Counseling, PLLC. I am glad you are here. My name is Robin Case. I am a licensed clinical social worker and licensed marriage and family therapist. I look forward to working with you. Please complete the Intake Form thoroughly. This will provide personal and family information about you, your counseling goals and objectives, and other information that I need from you to get started.

PERSONAL INFORMATION

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

Street Address:_____City/State:_____Zip Code:_____

Cell Phone:_____ Home Phone:_____ Okay to text you? □ Yes. □ No.

E-Mail Address:_____ Okay to email you? □ Yes. □ No.

Sex: □ Female □ Male □ Gender Neutral:_____

Religious preference:_____

Employer:_____ Occupation:_____ Office phone:_____

Emergency Contact: Name:_____ Phone:_____ Relationship:_____

INSURANCE INFORMATION: *Please provide your insurance card so that I may make a copy.*

Primary Insurance Carrier:_____ ID#:_____ Group #:_____

Insured:_____ Date of Birth:_____ Relationship to insured:_____

Insurance Company Phone # (Mental Health):_____ Employer:_____

SOCIAL / FAMILY INFORMATION

Which best describes you? □ Single □ Dating □ Living with Someone □ Engaged □ Married □ Same-Sex Partners

□ Separated □ Divorced □ Widowed

Are you in a romantic relationship? □ Yes □ No If so, for how long?_____ How satisfied are you with the relationship?_____

Names / Ages of any children living with you:_____

Are there other individuals living in your home (other than listed above)? □ Yes □ No. If so, who?_____

Do you have any pets in the home? If so, what type?_____

Estimate how many hours a day you spend online (Facebook, YouTube, internet gaming, browsing, etc.):_____

What gives you the most joy in your life?_____

What are your main worries and fears?_____

MEDICAL AND MENTAL HEALTH INFORMATION

Are you currently being treated by a physician for any medical conditions? □ Yes □ No If so, please describe:_____

_____

Are you taking prescription, over-the-counter, or herbal medication? □ Yes □ No; If so, please list:_____

_____

Have you had any major illnesses, hospitalizations or surgeries? □ Yes □ No; If so, when, or approximately when?_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

□ Anger /Anger Outbursts	□ Difficulty Concentrating	□ Isolated/ Socially Withdrawn/ Lonely
□ Anxiety	□ Drug Use/Abuse/Addiction	□ Gambling
□ Abandonment	□ Easily Startled	□ Headaches
□ Alcohol Use/Abuse/Addiction	□ Eating Issues (under or over-eating)	□ Insomnia (difficulty sleeping)
□ Aggression	□ Fears / Phobias	□ Intrusive / Unwanted Memories
□ Avoiding People	□ Fatigue	□ Impulsivity
□ Crying	□ Feeling Abandoned	□ Irritability
□ Cyber Addiction	□ Feeling Hopeless	□ Excessive Worry
□ Nightmares	□ Self-Harm	□ Racing Thoughts/Can't stop thoughts
□ Sexual Addiction	□ Sexual Difficulties	□ Panic Attacks
□ Frequently Sick / Unhealthy	□ Suicidal Thoughts / Actions	□ Thoughts of Harming Others

COUNSELING CONCERNS

What specific issues or circumstances have led to your desire to seek assistance at this time? Please be as specific as possible:

1. _____ 3. _____

2. _____

What have you previously tried in order to resolve these issues (e.g., counseling, spiritual/pastoral counseling, talking with family / friends)?_____

If so, was it helpful? □ Yes □ No . Please explain_____

What are some of your coping strategies, and what do you consider to be your strengths?_____
_____

COUNSELING GOALS

Goals are very important in counseling. They provide us with a focus and direction that will help me to help you. Please list the goal(s) that you hope to achieve in counseling. Please be as specific as possible.

1. _____ 2. _____

3. _____

RISK ASSESSMENT

Have you been having any thoughts of harming yourself or any other person(s)? □ Yes □ No □ Self □ Other(s)

Are there any guns or weapons in your house (specify whose gun(s) & what type)?_____

_____.

Has a family member or close friend ever committed suicide? □ No □ Yes, (Who)_____

Is there any personal history of emotional, physical, and /or sexual abuse: □ Yes □ No If so, please explain:_____

_____

_____.

Is there any family history of mental health issues, mental illness, or substance abuse? □ Yes □ No If so, please list

their relationship to you & their diagnosis:_____

Have you ever been involved in any significant legal actions, currently or in the past? (e.g., lawsuit, probation, parole) □ No □ Yes. If Yes, please explain the circumstance(s):_____

_____

ALCOHOL / SUBSTANCE ABUSE SURVEY

How often do you have a drink containing alcohol?

□ Never □ 1 x month or less □ 2-4 x month □ 2-4 x week □ more than 4 per week

How many drinks containing alcohol (12 oz beer, 5 oz wine, or 1.5 oz distilled spirit) do you consume on a typical day when you are drinking?

□ 1 or 2 □ 3 or 4 □ 5 or 6 □ 7 to 9 □ 10 or more

Do you use marijuana or other "street drugs"? How about prescription drugs? (Remember, this information is confidential). □ No □ Yes; what type / quantity / frequency of use:_____

If you prefer not to answer in writing and choose to discuss this privately with me, check here □.

Referral Source

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

□ Insurance Co._____ □ Physician_____ □ Attorney_____

□ Advertising (source)_____ □ Internet_____ □ Friend_____ □ Other_____

By signing below, I confirm that the information I have provided is true and correct. My signature below also indicates my desire and consent to receive mental health services from Case Counseling, PLLC.

Client Name (please print):_____

Client Signature:_____ Date:_____/_____/_____

CASE COUNSELING, PLLC

Client Financial Agreement

CANCELLATION AND MISSED APPOINTMENT POLICY

I understand that my appointment time is reserved for me at the exclusion of others who may be waiting to see the therapist. I understand that if I am not able to attend my appointment, I must give 24-hour advance notice to cancel the appointment without being charged. If I cancel on the day of my appointment, my account will incur a $50 fee, and if I fail to show without any advance notice, my account will incur a $100 fee. I agree to call the office at (972) 691-4999 if I need to cancel or re-schedule my appointment, and I am aware the voicemail system records the date and time of all messages left.

FEES, PAYMENT, AND INSURANCE REIMBURSEMENT

I understand that I am fully responsible for the payment of all fees for services provided by Case Counseling, PLLC. I understand that if I have insurance, Case Counseling, PLLC will either file the claim on my behalf or will provide me with the necessary information so that I may file the claim myself. I understand that I am ultimately responsible for any therapy fees not covered by my insurance carrier. Co-pays and non-covered services are payable at the time of service. In the event that insurance is billed on my behalf, my signature below authorizes payment of mental health benefits to Case Counseling, PLLC.

I understand that it is Case Counseling, PLLC policy that the fee for any session is payable at the beginning of the session. Case Counseling, PLLC accepts cash, checks, credit cards, or Venmo as forms of payment. All sessions are 45 – 50 *minutes in length* (longer sessions may be available for an additional fee). The fee for an initial intake session is $165 and the fee for follow-up sessions is $150. My therapist may offer me a sliding scale fee based upon my income (which would be determined at the time of my initial intake). While sessions are not typically conducted by phone, if an emergency phone consultation is initiated by the client, the first 10-minutes are at no charge. However, $37.50 will be billed to your account for each subsequent 15-minute period. This same fee schedule applies to non-emergency communication for unscheduled appointments involving counseling that takes place during business hours or after business hours. Should you request a copy of your counseling records, please be advised there is a $50 record preparation fee (and a "Release of Information" must be signed documenting that I am releasing your records to you).

My signature below indicates that I have read, understand, and agree to the statements made in this Client Financial Agreement regarding Cancellations and Missed Appointments & Fees, Payment, and Insurance Reimbursement. I authorize and agree to have my credit card information (as listed below) kept on file and charged for Late Cancel appointments, No Show appointments, and other outstanding balances on my account that have not been paid or payment arrangements made after 30 days.

By signing below I also certify that the credit card information I am providing is accurate and I am an authorized user on the credit card account.

Client Name (please print):_____

Client Signature:_____ Date:_____/____/_____

☐ VISA ☐ MASTERCARD ☐ HSA CARD	CARD NUMBER	EXP DATE	CVV CODE
I hereby give consent to charge my credit card for any outstanding balance at the end of each month such as deductibles, co-payments, various fees described in the Client Financial Agreement above, or other amounts my insurance carrier determines as payable by me.		CARD HOLDER NAME	
CARD HOLDER SIGNATURE		DATE	

CASE COUNSELING, PLLC

Limits of Confidentiality and Client Rights

Limits of Confidentiality

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

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

Client Bill of Rights

Case Counseling, PLLC does not discriminate on the basis of religion, race, gender, marital status, age, sexual orientation, national origin, previous incarceration, disability, or public assistance status.

Every client shall:

* be informed prior to, or at the time of the intake appointment of services available at Case Counseling, PLLC and of any financial charges that are the client's responsibility to pay beyond the coverage of insurance.
* expect complete and current information concerning his or her diagnosis and individual treatment plan in terms he or she can understand.
* have the right to know by name, and the competencies of, the licensed mental health professional responsible for coordination of his or her treatment.
* have the freedom to place grievances and recommend changes in policies and services to Case Counseling, PLLC staff free from restraint, interference, coercion, discrimination, or reprisal.

In addition to the rights listed above, services offered by practitioners licensed by the State of Texas have the right to: (a) expect that a practitioner has met the minimum qualifications of training and has the experience required by state law; (b) examine public records which contain the credentials of the practitioner; and (c) obtain a copy of the rules of conduct.

By my signature below, I agree that I understand my right to confidentiality and the above noted exceptions.

Client Name (please print):_____

Client Signature:_____ Date:____/____/_____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. This notice describes how your health information may be used and disclosed and how you can access this information. Please review carefully.

When the therapist at Case Counseling, PLLC consults, evaluates, diagnoses, treats, and/or refers you (the client or minor client that you represent), the therapist will be collecting what the law calls "protected health information" (PHI) about you or your minor. At Case Counseling, PLLC, the therapist is very careful to keep your health information secure and confidential. The HIPAA law requires the therapist to maintain your privacy, to give you this notice, and to follow the terms of this notice. The law permits the therapist to use or disclose your health information to those involved in your treatment; or to disclose your health information for payment of your services from your insurance company; or in an emergency, the therapist may disclose your health information to a family member or another person responsible for your care. The therapist also may release some or all of your health information when required by law (please refer to Case Counseling, PLLC "Limits of Confidentiality").

If you are concerned about your PHI, you have the right to ask the therapist not to use or share some of it for treatment, payment, or administrative purposes. You will need to submit any limitation requests in writing. Although the therapist will try to respect your wishes, the therapist is not legally required to accept these limitations. You have the right to know of any uses or disclosures the therapist may make with your health information. You have the right to transfer copies of your health information to another practice. You have the right to request an amendment or change to your health information. If such a request is made, you will be required to submit your amendment or change request in writing. If you wish to include your statement in your file, please give it to the therapist in writing. The therapist may or may not make the changes you request, but will agree to include your statement in your file. If the therapist agrees to an amendment or change, the therapist will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If the therapist changes any details of this notice, the therapist will notify you of the changes in writing. If you believe that your privacy rights have been violated, you may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, the therapist asks that you please discuss the matter with the therapist beforehand.

By signing this form, you are agreeing to let Case Counseling, PLLC use your PHI in the manner described above. Your signature below acknowledges that you have read this notice and are aware of Case Counseling, PLLC notice of privacy practices.

Client Name (please print):_____

Client Signature:_____ Date:_____/_____/_____

Electronic Communication and Contact Policy

SOCIAL NETWORKING

The therapist at Case Counseling, PLLC does not accept friend requests from current or former clients on social networking sites (e.g., Facebook) due to the fact these sites can compromise both the clients' and therapist's confidentiality and privacy. For the same reason, Case Counseling, PLLC requests that clients do not communicate with the therapist via any interactive or social networking websites.

IN PERSON, OUTSIDE OF THERAPIST'S OFFICE

In an effort to further protect your confidentiality, if your therapist sees you in public, the therapist will only acknowledge you if you approach the therapist first.

TEXTING POLICY

If you checked "yes" on your Intake Form indicating that you give your permission for your therapist to contact you via text, you may be contacted to schedule, confirm, or cancel an appointment with your therapist. Unless otherwise stated by your therapist, texting your therapist should be limited to scheduling or confirming an appointment or notifying the therapist that you may be running late for an appointment. Please be advised that texting is not an appropriate method of reaching out to your therapist in a crisis.

PHONE CONTACT

Outside of your regular scheduled sessions, in the event of a crisis, one brief (no more than five to ten minutes) phone call is acceptable on occasion between sessions. It is important that you first consider utilizing your therapy tools, and other support systems between therapy sessions before contacting your therapist unless it is an emergency or crisis situation. For phone consultations exceeding ten minutes, you will be billed in accordance with the Client Financial Agreement. If you are suicidal or have a life threatening situation, please call 911 immediately.

E-MAIL CONTACT

Outside of your regular scheduled sessions, a short email (no more than a paragraph) is acceptable on occasion between sessions. Your emails should be geared toward confirming or changing appointments, and not discussing therapeutic topics, sending photos, jokes, or other such emails as the relationship is of a professional therapeutic nature. Any other topics outside of this are best saved for your session.

RESPONSE TIME

Please allow at least 24-hours for a reply regarding routine matters. As your therapist sees numerous clients per week, she may receive multiple emails and calls from many clients. Please be considerate of your therapist's personal time.

My signature below indicates that I have read and agree to Case Counseling, PLLC' Electronic Communication and Contact Policy

Client Name (please print):_____

Client Signature:_____ Date:____/_____/_____

CASE COUNSELING, PLLC

Court Testimony and Deposition Agreement

This therapist **DOES NOT** voluntarily appear in court on behalf of individual, children, or families. Case Counseling, PLLC services are designed to assist clients with their difficulties through individual or relational psychotherapy. This therapist does not typically maintain the type of records intended for use in court.

In addition, the legal process is such that the therapist may be compelled to reveal information about you that could affect you negatively or undermine your relationship with your therapist. Therefore, because the client-therapist relationship is built on trust with the foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, or to testify to whether certain matters are factual or in an expert nature, in court or deposition.

In the event that it is necessary, by court order or by subpoena, for the therapist to testify before any court, arbitrator, or other hearing officer, or to testify at a deposition, whether the testimony is "factual" or "expert", or is required to present any or all records pertaining to the counseling relationship to a court official or attorney's , the client agrees to pay the therapist for her time and services. These billable services include, but are not limited to: travel, necessary expenditures (e.g., copies, parking, meals, etc.,), time spent speaking with attorney's, reviewing records, and preparation of reports. Case Counseling, PLLC charges a rate of $125 per hour for court and deposition preparation plus per diem for mileage and meals, and actual expenses for hotel, airfare, rental cars and so forth.

If the therapist receives a subpoena to appear in court or at a deposition on a certain date, the therapist requires a 10-day notice prior to the hearing in order to cancel other Case Counseling, PLLC clients that have already scheduled appointments for that particular date. As such, Case Counseling, PLLC will require payment of $1,600 for the entire day (10 days prior to required appearance date) when the subpoena is served. If payment and proper notice are not provided, the client agrees the subpoena is waived, the therapist will not cancel standing client appointments that are already scheduled for office visits, and the therapist will not appear in court or at the deposition. The client should notify his or her attorney of this stipulated agreement prior to signing this agreement if the client is contemplating using this therapist for court appearance or deposition.

Initial one of the following:

_____I AM seeking counseling for court testimony or court involvement on behalf of my therapist at Case Counseling, PLLC.

_____I AM NOT seeking counseling for court testimony or court involvement on behalf of my therapist at Case Counseling, PLLC.

By signing this form, you are acknowledging you have notified Case Counseling, PLLC (before a counseling relationship is established) that you and / or your child are or are not attending counseling for court or court related purposes / motivations. Furthermore, you agree to the stipulations of this agreement and will abide by the agreement as stipulated.

Client Name (please print):_____

Client Signature:_____ Date:____/____/_____

Therapist Signature:_____ Date:____/____/_____