Adult Intake Form

West Houston Counseling Center, PLLC
707 South Fry Rd., Suite 465, Katy, Texas 77450
Phone: (281) 940-8515 Fax: (888) 972-1582
www.WestHoustonCounseling.com

Client Information:

Name: ____ **Today's Date:** __________________________ **Sex:** *M* *F*
Age: _____ **Birth date:** ________________ **Social Security Number:** ______________________________________
Relationship Status: Single Married Long-term Relationship Divorced Separated Widowed
Occupation: ___________________________________ **Employer:** ____
Address: ____
Home Phone: _______________________________ **Cell Phone:** ____
Email Address: ______________________________________ **Permission to confirm appointments via email?** *Y* *N*

In the event of an emergency, whom should we contact?
Name: ____ Relationship: ______________________________________
Cell Phone: _____________________________________ Email: ____

Please provide a copy of both sides of your insurance card and driver's license for verification of benefits and identity.

Responsible Party

Name: ____ Birth Date: __________________________
Address: ____
Driver's License # ______________________ SS#__________________________ Phone:__________________________

INSURANCE INFORMATION

Who is the insured? _________________________________ SS#: ______________________ Birth Date: _______________
Relationship to Client: ____ Cell Phone: __________________________
Employer of the insured: ____ Work Phone: _________________________
Insurance Company Name:__________________________ Insurance Phone # for Mental Health: ____________________
Member ID#: _______________________________________ Group ID#:____

I authorize the release of any medical or other information necessary to process an insurance claim. I understand that West Houston Counseling Center, PLLC will diligently attempt to get accurate information regarding my mental health insurance benefits. I will not hold West Houston Counseling Center liable for insurance nonpayment due to misquoted benefits. I will not hold West Houston Counseling Center responsible to know and understand my benefits plan. West Houston Counseling Center will file my insurance claims for me as a courtesy. I am ultimately responsible for all charges my insurance company does not pay, except for contracted network provider discounts that may apply. I also request benefits be paid to West Houston Counseling Center.

Signature of Client and/or Responsible Party: ____

Date: ____

Client Name: ____ **Date:** ________________

Have you ever sought counseling before? **Yes** **No**

If yes, name of professional: ___________________________ **Duration of counseling:** ________________

How did you hear about this center? ____

Medical Information:

Doctor's name__________________________________ **Office Phone:** __________________________

Address: ____

Psychiatrist's name _____________________________ **Office Phone:** _________________________

Address: ____

Please list current medications with dosage and frequency: _____________________________________

____

Any problems with past or present medications: ____

____

Do you have any chronic medical or mental health conditions? ***Y N*** **If so, please list:** ________________

____

Your Education:

Where did you attend public school? ____

Did you attend college/professional school? When, where, degree earned? ____________________________

____

Any plans to further your education? ***Y N*** **If so, when and what?** ______________________________

____

Problem Description:

Please list the main reason for seeking counseling at this time:_______________________________________

____

What would you like to get out of counseling at this time? ____

____

Is there anything else you would like us to know? ____

____

Your Relationships:

Please list your marriage(s) or other important significant-other relationships:

Partner's Name	Year Begun	Year Ended	Married to this person?	Children from this relationship & their ages

Client Name: ______________________________ **Date:** ______________

Home Information:

List all persons living in the home:

Name	Age	Relationship

Your Family:

Relative	Name(s)	Living?	Current age Or age at death	Occupation	Describe the relationship
Father					
Mother					
Brother(s)					
Sister(s)					
Other					

Please check all of the items below that you are currently experiencing. Feel free to add any others at the bottom under "Other Concerns or Issues."

Abuse – emotional	Impulsive spending	Self abuse - burning
Abuse – neglect	Impulsiveness	Self abuse - cutting
Abuse – physical	Indecision	Self abuse – other
Abuse – sexual	Inferiority feelings	Self abuse – scratching
Aggression	Inhibitions	Self-centeredness
Anger	Interpersonal conflicts	Self-control
Anxiety	Irresponsibility	Self-esteem
Arguing	Irritability	Self-neglect
Attention problems	Judgment problems	Separation
Career concerns	Laziness	Sexual conflicts
Childhood issues	Legal matters	Sexual desire differences
Children – care of	Loneliness	Sexual dysfunctions
Children – custody	Loss of control	Sexual – other issues
Children – management	Losses	Shyness
Choices I have made	Low energy	Sleep – insomnia
Codependence	Low frustration tolerance	Sleep – nightmares
Compulsive spending	Low income	Sleep – too little
Concentration problems	Low mood	Sleep – too much
Confusion	Marital coldness	Step-parenting
Crying	Marital conflict	Stress

Client Name: ____ **Date:** ____________________

Deaths	Marital distance	Stress-management
Debt	Marital infidelity / affairs	Suicidal thoughts
Decision making	Medical concerns	Suspiciousness
Delusions – false ideas	Memory problems	Temper problems
Dependence	Menopause	Tension / stress
Depression	Menstrual problems	Thought disorganization
Distractibility	Mixed feelings	Threats of violence
Divorce	Mood swings	Tiredness
Drug abuse – over the counter	Motivation	Tobacco Use
Drug abuse – prescription	Mourning	Violence
Drug abuse – street drugs	Obsessions	Violence – victim of crime
Drug abuse – alcohol	Outbursts	Work problems
Eating – poor appetite	Oversensitive to criticism	Weight and diet issues
Eating – making myself vomit	Oversensitive to rejection	Withdrawal – isolating
Eating – overeating	Panic or anxiety attacks	Employment problems
Eating – under-eating	Parenting	Employment – lack of
Emptiness	Perfectionism	Employment – overdoing
Failure	Pessimism	Employment – termination
Fatigue	Phobias	**Other Concerns or Issues:**
Fears	Physical problems	
Financial troubles	PMS	
Friendship problems	Poor self-care	
Gambling	Procrastination	
Goals not being met	Relationship problems	
Grieving	Relaxation	
Guilt	Re-marriage	
Headaches / pains	Risk taking	
Health	Sadness	
Hostility	School problems	

Client Name: ____ **Date:** __________________

West Houston Counseling Center, PLLC
Credit Card Authorization
All clients must have a credit card on file to receive services.

Please make no marks or add comments to this page of the document. It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modification. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the case that you miss or fail to cancel an appointment within 24 hours of the scheduled time, you will be charged a $50 fee. If a check is returned unpaid, your credit card will be charged the amount of the check. An additional $35 fee will be assessed for 1) returned checks, and 2) inaccurately disputed claims/charge backs.

I, ____, hereby authorize West Houston Counseling Center, PLLC, to bill my credit card at the usual fee for professional services including all of the following:

- Appointments and/or copayments that I elect to pay for by credit card
- Missed appointments
- Telephone, email, and Skype consultations
- Appointments that I have cancelled with less than a 24-hour notice
- Returned checks
- Fees not covered by insurance or insurance payments made to patient rather than provider

Credit Card Type (check one):

____ Visa ____ MasterCard ____ Discover

Card # ____ Expiration Date: ____________________

Name as Printed on Card: ____

Verification/Security Code (3 digit code on back of card by signature line): _______________________

Billing Address: ____

City: ____________________________________ State: ____________ Zip: ______________________

By signing below I am authorizing West Houston Counseling Center, PLLC to bill my credit card at the usual fee for professional services. I will not dispute charges (“charge back”) for sessions I have received or appointments I have missed according to the above policy.

Signature: ____ Date: ____________________

Print Name: ____

Client Name: ____ **Date:** __________________

Client Informed Consent

Counseling Relationship: We schedule appointments based on availability and your need. If you experience a mental health emergency, obtain crisis services by dialing 911 and/or by going to a nearby hospital emergency room.

Effects of Counseling: At any time, you may initiate discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed and sometimes things may get worse before they get better. Together we will work to achieve the best possible results for you.

Client Rights: Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. You also have the right to refuse or discuss modification of any of our counseling techniques or suggestions that you believe might be harmful. If you are concerned about slow progress or lack of progress, you have the right to speak about your concerns.

We assure you that our services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with our services, please let us know. If we are not able to resolve your concerns, you may report your complaints in writing to the Complaints Management and Investigation Section, Texas State Board of Examiners of Professional Counselors.

Cancellation: In the event that you will not be able to keep an appointment, please notify us by phone at least 24 hours in advance to avoid payment. If this 24-hour notice is not respected, you will be charged a $50 fee. Cancelling an appointment means you are not able to make the scheduled appointment time. If you choose to reschedule your appointment at the time you call to cancel, that does not remove any fees for your cancelled appointment. This fee must be paid before additional sessions may be scheduled. An additional $35 fee will be assessed for 1) returned checks, and 2) inaccurately disputed claims/charge backs.

Session Fees: Therapist fees range by licensure status and experience. Your fee per session is __________.
Therapist and client initials ___________________

___________ LPC

Please understand that an LPC is not a psychiatrist, but a licensed Master's level therapist, and as such cannot recommend or prescribe medications but can encourage clients to see a physician for a medical evaluation.

___________ LPC-Intern

An Intern has earned a Master's degree and is provisionally licensed while gaining the necessary clinical hours to receive full licensure. Your name and certain aspects of your case may be disclosed to supervisors during the course of supervision so that you receive the best care possible. Your counselor does not provide legal and/or disability input.

___________ Graduate Level Counselor

A graduate level counselor is a Master's level student in a counseling related field and is not licensed. Your name and certain aspects of your case may be disclosed to supervisors during the course of supervision so that you receive the best care possible. Your counselor does not provide legal and/or disability input.

Legal Fees*: We have no forensic experience therefore we would generally not be a good expert witness. However, in the event of court proceedings where we are court-ordered to appear, or our records are needed, our hourly fee is $200 for any amount of work performed including reports, drive time, wait time, depositions and court proceedings. We require a retainer fee of a minimum of $600 no later than 48 hours before the court date. The fee for copying records will be a $30 processing fee plus $0.50 per page.
*A 10% charge will be added to all outstanding balances over 30 days, and all returned checks will incur a $30 fee.

Confidentiality: All of our communication is confidential, except in the following cases: a) We determine that you are a danger to yourself or someone else; b) You disclosed abuse, neglect, or exploitation of a child, elderly, or disabled person; c) You disclose sexual contact with another mental health professional; d) We are ordered by court to disclose information; e) You direct us to release your records; or f) We are otherwise required by law to disclose information. If we see you in public, we will protect your confidentiality by acknowledging you only if you approach us first.

I understand that if I am working with a therapist for couples counseling, the relationship is considered the client. I understand that anything I tell my therapist individually, whether in person, on the phone, or through written communication, will not be held as confidential and may be shared with the spouse/partner at the therapist's discretion. This policy is intended to maintain the integrity of the counseling relationship between both members of the couple and the counselor, as well as avoiding a conflict of interest. I understand that my therapist will not keep secrets which jeopardize the therapeutic work of the relationship counseling. If at any point, you feel that you need to share information that must be kept from your partner/spouse, you may request a referral to another counselor for individual therapy.

By your signature below, you are indicating that you read and understood this statement, or that any questions you had about this statement been answered to your satisfaction and that you were furnished a copy of this statement if one was requested. By our signature, we verify the accuracy of this statement and acknowledge our commitment to conform to its specifications.

____ _________________________________

Client Signature Date

Client Name: ____ **Date:** __________________

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name: ____

Date of Birth: ____

Parent/Guardian Name: ____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of West Houston Counseling Center's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can talk to my counselor about it or contact Jana Henry or Melissa Melnar at West Houston Counseling Center. I understand that I may also contact the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201.

________________________________ ________________________________
Signature of Client Date

________________________________ ________________________________
Signature of Parent, Guardian or Date
Personal Representative
(If client is under 18 years of age) * If you are signing as a personal representative, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Client Refuses to Acknowledge Receipt (reason):

________________________________ ________________________________
Signature of Staff Member Date

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