101 King Plaza, Suite D
Commerce, TX 75428

Phone: 903-375-0048
Fax: 903-246-3309
P.O. Box 1316
Email: drnick@ccwnt.com
Website: www.ccwnt.com

THERAPY INTAKE PACKET (Adult)

Included in this Packet:

(1) Information & Consent Form (p. 2-9)
(2) Notice of Privacy Practices (p. 10-11)
(3) Acknowledgment of Receipt of NPP (p.12)
(4) Intake Questionnaire (p. 13-17)
(5) Financial Agreement (p. 18)
(6) Credit Card Authorization Form (p. 19)

Instructions:

Before your Appointment:

(1) Read and Sign/DATE the **CCWNT Office Copy** of the **Information & Consent Form**
(Keep the Client Copy that is printed for you)
(2) Complete the **Intake Questionnaire**
(3) Review the **Notice of Privacy Practices (NPP)**
(4) Sign/Date the **Acknowledgment of Receipt of NPP**

Bring to your Appointment:

(1) The signed **CCWNT Office Copy** of the **Information & Consent Form**
(2) Your completed **Intake Questionnaire**
(3) the signed **Acknowledgment of Receipt of NPP**

Therapy Information and Consent Form (Adult)
(Client Copy – Retain for your records)

Services Provided
The Center for Counseling & Wellbeing of Northeast Texas PLLC (CCWNT) offers a variety of counseling services provided by counselors, licensed professional counselor associates, and psychology and counseling graduate students.

Psychotherapy
Psychotherapy can have both risks and benefits. The therapy process may include discussions of personal challenges, and difficulties which can elicit uncomfortable feelings such as sadness, guilt, irritability, and frustration. However, psychotherapy has also been shown to have many benefits. It can often lead to better interpersonal relationships, improved academic performance, solutions to specific problems, and reduction in feelings of distress. But, there is no assurance of these benefits.

Fees for Service
The Center for Counseling & Wellbeing of Northeast Texas' clinicians are individually contracted with insurance companies. Not all clinicians take insurance, and some take only certain panels. If we are in-network with your insurance, we will attempt to verify benefits before your first session and file claims accordingly. Please note that we are only able to provide you with an estimate of benefits and the insurance company reserves the right for the final approval. You will be responsible for charges which are not covered or contracted by insurance. If we are not in-network, we will provide you with a Superbill, upon request, so that you may file with your insurance company. There will be a fee of **$10** should you chose to request medical records. Medical records sent to another provider of services will not incur a fee.

Confidentiality
In keeping with professional ethical standards and state and federal law, all services provided by the staff of CCWNT are kept confidential except as noted below and in the accompanying *Notice of Privacy Practices*. We consult as needed within the staff of CCWNT about the best way to provide the assistance that you might need. As required by practice guidelines and current standards of care, we keep records of all therapy sessions. These records are stored securely in a manner consistent with federal and professional security standards for counseling records. All requests for records should be done in writing, with a Release of Information form. Please be advised, a succession plan is in place if your clinician should become seriously ill, impaired in some capacity, or pass away unexpectedly.
CCWNT professional staff have a legal responsibility to disclose client information without prior consent when a client is likely to harm themselves or others unless protective measures are taken, when there is reasonable suspicion of abuse of children, dependent adults, or the elderly, when the client lacks the capacity to take care of themselves, or when there is a valid court order for the disclosure of client files. Fortunately, these situations are infrequent.
By signing this form you also give CCWNT permission to communicate with the Emergency Contact that you have designated if we believe that you are at risk. If you are suing someone or being sued, or if you are charged with a crime and you tell the court that you are a client of CCWNT, CCWNT or your therapist may then be ordered to show the court your records. Please note, As of 2015 in the state of Texas, psychologists (and any clinician in training) are not permitted to provide statements in court regarding appropriate custody of a minor, parental fitness(which parent is a psychologically better fit to raise the child), and / or parental alienation unless they have had specialized training in this area (usually referred to as Forensic Psychologists). Please consult with your clinician regarding their training in this area and with your lawyer should you believe these issues may arise. Please consult with your therapist if you have any questions about confidentiality. There are additional fees associated with the clinician's involvement with legal matters such as testifying in court, consult with law professionals, and preparation of legal documents. **If you are in family therapy with a minor:**
I understand that if my child has parents that are divorced and / or part of a joint custody agreement, I must furnish the clinician with a copy of the divorce decree and most current child custody arrangement and / or provide any updates and changes before work can begin per Texas state law.

Policies

In general, you may review your records in CCWNT's files at any time. There are some limitations regarding raw testing data, but for the most part, you have access to your information. You may add to this information or correct this information, and you may have copies of the records. However, you may not examine records created by anyone else and sent to CCWNT. In some very rare situations, parts of your records may be temporarily removed before you see them. This would happen if it is determined that the information would be harmful to you; nevertheless, the therapist or appropriate CCWNT staff shall discuss this with you if it becomes an issue.

CCWNT is not an emergency or crisis intervention facility. In the event of an emergency or crisis between scheduled appointments, go to the nearest emergency room or seek help by calling 988 (all ages), or call 911 if it is a life-threatening situation.**Use of electronic mail/text features/social media**

Please be aware that e-mail may not be private or confidential and may not be read by the recipient in a timely fashion. With regards to any client of CCWNT (adult or minor), your clinician will not communicate therapeutic information via email. Your clinician will not provide updates on your or any minor's symptoms, presenting issues, or treatment feedback via email, regardless of your choice to communicate such information to the clinician. **Additionally, not all clinicians have work phones with text features; however, if this feature is available only scheduling information should be discussed.** Please ask your clinician if texting is an option. Clinicians work to protect your privacy, thus will not accept requests for connecting or messaging on social media sites.

Location-Based Services

Please be aware if you use location-based services on your mobile phone you may compromise your privacy while attending sessions at the office. The office is not a check-in location on various sites such as Facebook, however it can be found as a Google location. Enabled GPS tracking makes it possible for others to surmise you are a counseling client due to regular check-ins at the office location.

Psychiatric consults and medication

CCWNT does not retain a psychiatrist on staff, nor do we prescribe or dispense psychiatric medications. CCWNT can provide you with a psychiatric referral if deemed necessary. You may sign a release to enable CCWNT to consult with your Psychiatrist.

CCWNT is a training and research site for psychologists and counselors

CCWNT is a training facility. Thus, the care you receive may be with a graduate counseling student, licensed professional counselor associate, or licensed professional counselor. All clinicians in training will inform you of their trainee status as well as the name of their supervising counselor who can be contacted through our office. In order to adequately supervise trainees, a supervisor may ask that therapy sessions be audio or video recorded. Any and all video sessions will **not** be a part of your formal record as they will be erased regularly. You have the right to review these tapes at any time and can request this through your therapist. You may choose not to have your sessions recorded. Please talk with your therapist if you have questions about audio and video recording.

Center For Counseling & Wellbeing of Northeast Texas PLLC

Therapy Information and Consent Form (Adult)
(CCWNT Copy – Retain for client records)

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Confidentiality and Exceptions to Confidentiality

Therapy comes with an assumption that what is said by you is kept confidential by your therapist. Certain law and prudent professional practice affect your therapist's choice to keep your information completely confidential. Please read the following carefully, discuss all concerns and questions with your therapist, and initial as appropriate. The following is not intended to be a guarantee that other circumstances will not arise which may impact confidentiality. You deserve to have exceptions to confidentiality discussed with you, but your legal rights are affected by outside influence, such as changes in the law.

- I, ____, understand that, if I am in imminent danger of harming myself or others:
- ________ My therapist may notify medical or law enforcement personnel without my permission.
- _________ I give my therapist permission to also notify the following person(s):

Name:____

Address: ____

Telephone: ____

Relation: ____

- ______ I understand that my therapist is required by law to report suspected child or elder abuse (65)
- ______ I understand that the use of third-party payment resources often requires reporting by my therapist of otherwise confidential information, such as diagnosis of a mental health disorder.

____ ________________________

Signature of Client or Client's Representative Date

____

Print Name

Consent
Please sign for CCWNT records

By signing below, I agree to enter into psychotherapy with a qualified CCWNT therapist. I understand I have the right **not** to sign this form. My signature below indicates I have read and discussed this agreement; it **does not** indicate that I am waiving any of my rights. I understand I can choose to discuss my concerns with th therapist before therapy begins. I understand that after therapy begins, I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns with the therapist before ending my treatment.

I understand that no specific promises have been made to me by the therapist or CCWNT staff about the results of psychotherapy.

Information obtained during my treatment will be confidential and privileged except for the limitations noted above.

Please sign below to indicate that you understand and agree to participation in psychotherapy at the Center for Counseling & Wellbeing of Northeast Texas (CCWNT) in accord with the policies outlined above.

____________________	____________________	__________
Client’s Printed Name	Signature	Date
____________________	____________________	__________
Clinician’s Printed Name	Signature	Date

Professional Disclosure Statement and Informed Consent

PLEASE INITIAL EACH ITEM:

_______ I understand that Dr. Nick Patras, LPC-S & CCWNT is licensed to provide individual, couple, and group counseling in the state of Texas.

_______ I understand that Dr. Nick Patras, LPC-S & CCWNT does not provide 24-hour crisis counseling.

_______ Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1 or go to an emergency room for assistance.

_______ I understand that during the time that we work together, we will meet weekly for approximately 50 minutes. While our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one.

_______ I also understand our contact will be limited to counseling sessions except that in case of a true emergency, you may call Dr. Nick Patras &CCWNT at the phone number provided.

_______ I understand that, that at any time, I may discuss possible positive or negative effects of participating in a counseling relationship.

_______ I understand that no specific results are guaranteed although benefits are expected from counseling. I also understand that counseling can improve as well as upset my equilibrium as well as that of persons in my family. Counseling is a personal exploration and may lead to changes in my life perspectives and decisions. These changes could be temporarily distressing.

_______ I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship. If at any time I am dissatisfied with the services of my therapist, I have a right to let him know. If I do not feel that the counselor/therapist may resolve my complaint, I may file a formal complaint through contact with the Texas Board of Examiners at 1-800-942-5540.

_______ I understand that our paths may cross in social situations but that our therapeutic relationship comes first, along with protection of my confidentiality, and that my therapist does not initiate the greetings.

_______ Should I believe that a referral is needed, my therapist will provide some alternatives including programs and/or people who may be able to assist me.

_______ I understand that the rate for individual counseling sessions is $110.00 for a 50-minute session for individuals.

_______ I understand that the rate for couples/partners counseling is $150.00 for a 50-minute session.

_______ I understand that all fees for counseling are due after each session.

_______ I understand that the rate for all subsequent therapy services such as: attending parent/teacher conferences, attending ARD meetings, conducting classroom observations, participating in legal depositions, interactions with insurance companies, phone calls over 5 minutes, etc. will be billed at $130.00 per hour in 10-minute increments.

________ I understand that conducting expert witness and testimonial services is not an area of interest for the therapist and should he be subpoenaed as a factual case witness or involved in court-related processes the therapist charges a retainer fee of $1,500.00, with an additional $240.00 every hour they are involved in legal depositions, case preparation, travel, and witness time.

________ I understand that if I do issue my therapist a subpoena without his approval (see above) that my subpoena will be directly turned over to the therapist's attorney and a bill will be rendered to me for immediate retainer fee payment.

________ I understand that if a check is returned, a processing fee of $25.00 will be assessed to my account. Additionally, I will need to make a cash or money order payment for the returned check and $25.00 processing fee. After a returned check, the therapist may require cash payment of future appointments.

________ I understand that if a check is not cleared up in 30 days, the therapist will file a suit with the Hunt County District Attorney's Office.

________ I understand that I am responsible for any appointments that are not canceled at least 24 hours prior to my appointment time, with the EXCEPTION OF AN EMERGENCY.

________ I understand that if I do not cancel my appointment 24 hours ahead of time, the fee for calling to cancel on the day of my appointment is $65.00.

________ I understand that if I do not show up for an appointment it will result in m being charged $110.00 for the full missed session. ($150 for couples counseling).

________ I understand that my records and all of our communications become part of the clinical record. Records are the property of Dr. Nick Patras & CCWNT. Adult client records are disposed of seven (7) years after the client has stopped receiving services.

________ I understand that while most of our communication is confidential there are, however, circumstances when disclosure can occur without my prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

- You are a danger to yourself or someone else
- In situations of suspected child, spouse, or elder abuse, it is the duty of the mental health provider to notify medical, legal, or other authorities.
- You disclose sexual contact with another mental health professional.
- If you are involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
- Your therapist is ordered by a court to disclose information.
- You direct your therapist in writing to release your records.
- Therapist is otherwise required by law to disclose information.

Notice of Privacy Practices (NPP)
[Client Copy – Retain for your records]

This notice describes how mental health information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully.

The Center for Counseling & Wellbeing of Northeast Texas is a teaching center. Graduate counseling and licensed professional counselor associates may participate in your care as a part of their mental health training programs. All care is overseen and supervised by a licensed mental health professional. All information describing your mental health treatment and related health care services ("mental health information") is personal, and we are committed to protecting the privacy of the personal and mental health information you disclose to us. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. When we disclose information to other persons and companies to perform services for us, we require them to protect your privacy, too. This Notice also applies to your counselor, professionals who provide care to you. We must also provide certain protections for information related to your medical diagnosis and treatment, including HIV/AIDs, and information about alcohol and other substance abuse. We are required to give this Notice about our privacy practices, your rights and our legal responsibilities.

WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION:

- For Treatment. For example, we may give information about your psychological condition or assessment to other health care providers, such as your family physician or another psychologist, to facilitate your treatment, referrals or consultations.
- For Payment. For example, a health care provider may contact your insurer to verify what benefits you are eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.
- For Healthcare Operations. For example, we may give information to University or professional mental health and training organizations to review the quality of care provided, for performance improvement or the training of health professionals. Other examples could include audits and administrative services, and case management and care coordination.
- For Appointments and Services. To remind you of an appointment or tell you about treatment alternatives or health related benefits or services.
- To Individuals involved in Your Care. For example, your parents, if you are a minor, or your conservator.
- With your written authorization we *may* use or disclose mental health information for purposes not described in this Notice.

WE MAY USE YOUR MENTAL HEALTH INFORMATION FOR OTHER PURPOSES WITHOUT YOUR WRITTEN AUTHORIZATION:

- As Required by Law when required or authorized by other laws, such as the reporting of child abuse, elder abuse, disabled or dependent adult abuse.
- For health oversight activities to governmental, licensing, auditing, and accrediting agencies as authorized or required by law including audits; civil, administrative, or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.
- In judicial Proceedings in response to court/administrative orders, subpoenas, discovery requests, or other legal process. If CCWNT and/or your clinician is subpoenaed to appear in court and provide testimony regarding our knowledge and experience of you and our assessment, we will assert privilege on your behalf. Nevertheless, if the judge insists we testify, we will testify truthfully and honestly to our thoughts and professional opinion.
- To Public Health Authorities to prevent or control communicable disease, injury, or disability, or ensure the safety of drugs and medical devices.
- To Law Enforcement for example, to assist in an involuntary hospitalization process.
- To the State Legislative Senate or Assembly Rules Committees for legislative investigations.

- For Research Purposes subject to a special review process, and the confidentiality requirements of state and federal law.
- To Prevent a Serious Threat to Health or Safety of an individual. We may notify the person, tell someone who could prevent the harm, or tell law enforcement officials.
- To Protect Certain Elective Officers including the President, by notifying law enforcement officers of potential harm.

YOU HAVE THE FOLLOWING RIGHTS:

- To Receive a Copy of this Notice when you obtain care.
- To Request Restrictions. You have the right to request a restriction or limitation on the mental health information we disclose about you for treatment, payment, or health care operations. You must put your request in writing. We are not required to agree with your request. If we do agree with the request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment.
- To Inspect and Request a Copy of your Mental Health Record except in limited circumstances. A fee will be charged to copy your record. You must put your request for a copy of your records in writing. If you are denied access to your mental health record for certain reasons, we will tell you why and what your rights are to challenge that denial.
- To Request an Amendment and/or Addendum to your Mental Health Record. If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record) of no longer than 250 words for each inaccuracy. Your request for amendment and/or addendum must be in writing and give a reason for the request. We may deny your request for an amendment if the information was not created by us, is not a part of the information which you would be permitted to inspect and copy, or if the information is already accurate and complete. Even if we accept your request, we do not delete information already in your records.
- To Receive an Accounting of Certain Disclosures we have made of your mental health information. You must put your request for an accounting in writing.
- To Request That We Contact You By Alternate Means (e.g., fax versus mail) or at alternate locations. Your request must be in writing, and we must honor reasonable requests.

CHANGES TO THIS NOTICE: The Center for Counseling & Wellbeing of Northeast Texas reserves the right to change or revise this Notice. If a revision is made to our policies and procedures, a revised copy will be posted in the office and a copy will be provided to you upon requests.
CONTACT INFORMATION: If you have any questions about this Notice, please contact the Center for Counseling & Wellbeing of Northeast Texas PLLC, 101 King Plaza, Suite D, Commerce, Texas, 75428, or by telephone at 903-375-0048. If you believe your privacy rights have been violated, you may contact the Texas Board of Examiners of Professional Counselors at 1-800-942-5540. You may also send a written compliant to the Secretary of the U.S. Department of Health and Human Services. **You will not be penalized for filing a compliant.**

Effective Date: May 1, 2012

Acknowledgment of Notice of Privacy Practices
[CCWNT Office Copy – Keep for Client Record]

The Center for Counseling & Wellbeing of Northeast Texas Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have received the Notice of Privacy Practices.

____ ____________________
Signature of Client or Client's Legal Representative *Date*

Center For Counseling & Wellbeing of Northeast Texas PLLC

Individual Therapy Intake Form

First Name: ________________________________ Last Name: ______________________________
Age: ____________ Birth Day _____________ Month: _______________ Year: __________
Ethnicity: ___________ Religion: _____________________ Marital Status: ____________
Sex/Gender: __________________ Number of Children: _______ Ages of Children: _____________
Home Address: ____
Who do you live with? ____
Cell #: _________________________________ Home #:___________________________________
Work #: ________________________________ Email: ____________________________________
Name of Emergency contact:____________________________ Phone: _______________________
Where would you like me to leave a message? ☐Home ☐Work ☐Cell ☐E-mail ☐None

For clients under 18 years of age:
Name of parent/legal guardian: ______________________ Phone: _________________
Name of parent/legal guardian: ______________________ Phone: _________________

EMPLOYMENT INFORMATION:

☐ On sick leave, as of this date: ___________________ Return to work date: ________________
I was: ☐ Full-time or ☐ Part-time at: ____
☐ Full-time at: _______________________________ Position: ___________________________
☐ Part-time at: _______________________________ Position: ___________________________
☐ Not working because: ____

ACADEMIC INFORMATION

☐ Not attending school. Highest level completed: _______________________________________
☐ Full-time at: _______________________________________ Grade/year: ________________
Program: _______________________________ Typical grades:_________________
☐ Part-time at: _______________________________________ Grade/year: ________________
Program: _______________________________ Typical grades: ________________

HOW YOU FOUND THIS CENTER:

☐ Word of mouth ☐ I'm a former client ☐ Physician referred ☐ Psychology Today
☐ Google, using these words: ____
☐ Other: ____

THE REASONS FOR YOUR VISIT:

____

____

____

____

How intense is your emotional distress?
(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)
Please describe:

____

____

Overall, **how much do the problems affect your ability to perform** at work or school, get along with others, and perform daily tasks such as chores?
(Mildly disruptive) 1 2 3 4 5 (Incapacitating)
Please describe:

____

____

When did these problems start? What was going on in your life at that time?

____

____

____

Have you ever attempted suicide or harmed yourself in any way? ☐Yes ☐No
Are you currently thinking about suicide or harming yourself in anyway? ☐Yes ☐No
Have you had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way? ☐Yes ☐No
Are you having any thoughts about harming anyone else in any way? ☐Yes ☐No

PSYCHIATRIC AND MEDICAL HISTORY

Please list any ***psychiatric or "mental"*** problems you have been diagnosed with:

____

____

Please list any ***medical or "physical"*** problems that you have been diagnosed with:

____

____

Please list any **medications you currently take**, and what you take them for:

____

____

____

Describe any allergies you have:

____

Do you have any chronic medical concerns? __________ Please list:

____

____

Name of **Family doctor:** ____________________________________ Phone: __________________________
Last check-up was during the month of: _______________________ Year: ___________________________
Results:

____

____

Name of **Psychiatrist**: _______________________________________ Phone: ___________________________
Last visit was during the month of: ___________________________ Year: ____________________________
Results:

____

____

Please check all of the items below that describe your situation:
□ Abuse/trauma – physical, sexual, emotional, neglect
□ Aggression, violence
□ Alcohol use
□ Anger, hostility, arguing, irritability
□ Anxiety, nervousness
□ Attention, concentration, distractibility
□ Career concerns, goals, and choices
□ Childhood issues
□ Co dependence
□ Confusion
□ Compulsions and/or obsessions (thoughts or actions that repeat themselves)
□ Decision-making, indecision, mixed feelings, putting off decisions
□ Delusions (false ideas)
□ Dependence
□ Depression, low mood, sadness, crying
□ Divorce, separation, marital conflict, infidelity/affairs
□ Drug use – prescription medications, over-the-counter medications, street drugs
□ Eating problems – overeating, under eating, appetite, vomiting
□ Emptiness
□ Failure
□ Fatigue, tiredness, low energy
□ Fears, phobias
□ Financial or money troubles, debt, impulsive spending, low income
□ Gambling
□ Grieving, mourning, deaths, losses, divorce
□ Guilt
□ Headaches, other kinds of pains
□ Health, illness, medical concerns, physical problems
□ Inferiority feelings
□ Impulsiveness, loss of control, outburts
□ Irresponsibility
□ Judgment problems, risk taking
□ Legal matters, charges, suits
□ Loneliness
□ Memory problems
□ Mood swings
□ Over sensitivity to rejection
□ Panic or anxiety attacks
□ Perfectionism
□ Pessimism
□ Procrastination, lack of motivation
□ Relationship problems (with friends, with relatives, or at work)
□ School problems
□ Self-centeredness
□ Self-esteem
□ Self-neglect, poor self-care
□ Sexual issues, dysfunctions, conflicts, identity issues
□ Sleep problems (too much, too little, insomnia, nightmares)
□ Spiritual, religious, moral, ethical issues
□ Stress and tension
□ Suspiciousness
□ Suicidal thoughts
□ Temper problems, self-control, low frustration tolerance
□ Thought disorganization and confusion
□ Threats, violence
□ Weight and diet issues
□ Withdrawal, isolation
□ Work problems, employment issues

MENTAL HEALTH TREATMENT HISTORY

Have you **ever been hospitalized for psychological or psychiatric reasons?** ☐ No ☐ Yes
If yes, please describe when and where you were hospitalized, and for which reasons.

____
____
____
____

Please tell us about any other **mental health professionals you have consulted with in the past** (approximate dates, type of professional seen, reason for the consultation, nature of the treatment, outcome of the treatment).

____
____
____
____
____

CURRENT HABITS
Please describe your **current** habits in each of the following areas:
Smoking: ____
Gambling:____
Drinking: ____
Drug Use: ____
Caffeine intake: ____
Exercise:____
Eating: ____
Sleeping:____
Fun and Relaxation:____

RELATIONSHIPS

Please describe **your relationships** with each of the following people, if applicable:

Biological Mother: ____

Biological Father: ____

Step-Parents: ____

Legal Guardians: ____

Siblings: ____

Extended family: ____

Your Children: ____

Friends: ____

Romantic partner(s): ____

Colleagues or classmates: ____

Total number of close, supportive, relationships: _____________________________________

STRESSFUL LIFE EVENTS

Please describe any **current significant or stressful life events** that you have been experiencing:

	No	Yes	If yes, please describe
Economic Problems?	☐	☐	
Difficulty accessing health care	☐	☐	
Legal issues or crime?	☐	☐	
Cultural issues?	☐	☐	
Family conflict or lack of support?	☐	☐	
Social problems?	☐	☐	
Educational or occupational difficulties?	☐	☐	
Housing problems?	☐	☐	
Grief or bereavement?	☐	☐	
Other?			

What are your positive qualities and skills? What do you like about yourself? What qualities have helped you to succeed at overcoming difficulties in the past?

Please tell us about your plans for the future (career, personal, etc.)

How motivated do you feel to work on things in therapy?

What are your goals for therapy? What would you like to achieve by attending therapy?

What concerns do you have about attending therapy or working on these problems?

Is there anything else that you would like to mention?

Center For Counseling & Wellbeing of Northeast Texas PLLC

Financial Agreement

________**Self-Pay**: I will be paying for the services I receive at this clinic. I will make a full payment of $_______ each time I come unless other approved arrangements have been made.

NOTE: If you choose this option, this clinic will not bill any insurance company at a later date.

___ **Insurance payment**: I will give all insurance information required to the staff and request that they submit the charges to my insurance company for payment. I understand my insurance may not pay in full or may deny my services. I understand that I am financially responsible for all my charges. This includes my deductible and/or co-pay. I authorize this clinic to furnish to my insurance company all information that may be required in order to process the claims for me and/or my dependents.

Please present your insurance card at the time of the initial appointment. If you **do not have your insurance card** please fill out the following **thoroughly**:
Name of Insurance: ____
Address of Insurance Company: ____
Policy/ID#:__________________________________ **Group#:** ________________________________
Name of Policy Holder:_______________________ **Employer**: _______________________________

<u>Assignment of Benefits</u>

I hereby instruct and direct my insurance company to pay for my services by electronic payment of check made out and mailed to: Center for Counseling & Wellbeing of Northeast Texas, PLLC, P.O. Box 1316, Commerce, TX, 75428. If my current policy prohibits direct payment to provider, I hereby also instruct and direct my insurance company to make the check out to me and mail it to the above address for the professional or medical expenses allowable for the professional or medical expenses allowable, and otherwise payable to me under my current policy as payment toward the total charges for services rendered. This is a direct assignment of my rights and benefits under this policy. I have agreed to pay any balance of said charges for professional services over and above this insurance payment. A copy of this assignment shall be considered as effective and valid as the original.

Client Signature (Parent if minor): ____ **Date:** __________

Therapist: ____ Witness: ________________________

Center For Counseling & Wellbeing of Northeast Texas PLLC

Credit Card Authorization Form For Ongoing Therapy Sessions

PLEASE PRINT OUT AND COMPLETE THIS AUTHORIZATION AND RETURN TO US.
All information will remain Confidential.

I, ___________________________________, give Center For Counseling & Wellbeing of Northeast Texas permission to charge the following credit card, debit card, flexible spending card, or health savings account for the following reasons:

- Counseling sessions
- Report/Paperwork Requests
- Records Requests
- Late Cancellations/ No Show
- Group Sessions

Name on card: ____

Card Number: ____Exp. Date: ____________

Billing Zip Code: ____ Security Code: ______________

Please Initial the following:

________ I understand that this release is limited to what I have agreed to above. If I would like to change the card information in the future, I will need to alert my counselor.

_________ I understand that should an account become overdrawn, I am responsible for any incurred fees.

_________ I understand that all credit cards are subject to a $3 convenience fee. I understand that this fee will be applied to each transaction on my card.

** If, for any reasons, multiple "charges" are processed as one single transaction – e.g., accrued charges/past due balances, multiple family members paying for individual sessions in a lump sum payment – one (1) $3 convenience fee would be applied for the transaction.*

_________ I agree that I will pay for services in accordance with the issuing bank cardholder agreement.

_________ I understand that this release is valid when I sign it, and that I may withdraw my consent to this release at any time, either verbally or in writing.

Card holder: Print Name, Sign, and Date below:

Printed Name: ____

Signature: ____ Date:__________________