

**Wilson Counseling Services**  
John Wilson, M.A.  
Licensed Professional Counselor  
1506 N. Greenville Avenue, Suite 200  
Allen, TX 75002 - Phone 972-838-6290

**CLIENT INFORMATION**

**Section 1.**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

*If I call you, which number do you prefer that I use. Please only list the numbers at which I may call you and leave a message with a person or on an answering machine:*

Phone numbers: 1. \_\_\_\_\_ 2. \_\_\_\_\_

E-Mail address \_\_\_\_\_

*Is it all right to contact you by e-mail? \_\_\_\_\_ We will only use your e-mail address during the time you are coming to counseling.*

Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_

Emergency Notification _____			
	Name	Relationship	Phone

**Section 2.**

Name of Insurance Company or name of Employee Assistance Program:

\_\_\_\_\_

Policy Number if applicable \_\_\_\_\_ GroupNumber: \_\_\_\_\_

Please list the name of the primary policyholder: \_\_\_\_\_

I give permission to the undersigned therapist to communicate with me by mail or phone at the address and phone numbers listed above. I also give them permission to communicate with my insurance company or employee assistance program for the sake of reimbursement and in order to coordinate treatment.

I also affirm to the accuracy of the information listed above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

## CURRENT HEALTH STATUS

Communication between behavioral health providers and primary care physicians is important to help ensure that you receive comprehensive and quality health care. We will not attempt to contact any physician without your consent unless it is an emergency.

Name or your present family physician \_\_\_\_\_

Phone Number \_\_\_\_\_

Month and year of last doctor s visit \_\_\_\_\_

Current Medical Issues \_\_\_\_\_

\_\_\_\_\_

Medications you presently take: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Name of psychiatrist (if any) \_\_\_\_\_

Phone number \_\_\_\_\_

Month and year of last visit with psychiatrist \_\_\_\_\_

Reason(s) you are seeing a psychiatrist \_\_\_\_\_

## Symptoms and Issues Checklist

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please put a check next to any symptoms that you have experienced in the last six months. Most people experience some of the symptoms listed below at different times in their life. Your honesty will help me best know how to help you.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Depressed Mood<br><input type="checkbox"/> Increased Anxiety<br><br><input type="checkbox"/> Mood Swings<br><br><input type="checkbox"/> Poor concentration<br><input type="checkbox"/> Sleeping too much<br><br><input type="checkbox"/> Grief over a loss<br><input type="checkbox"/> Difficulty with memory<br><br><input type="checkbox"/> Specific fears or phobias<br><input type="checkbox"/> Impulsivity<br><input type="checkbox"/> Hallucinations<br><input type="checkbox"/> Marital problems<br><input type="checkbox"/> Past drug or alcohol abuse | <input type="checkbox"/> Crying Spells<br><input type="checkbox"/> Changes in appetite<br><br><input type="checkbox"/> Insomnia – inability to Sleep<br><input type="checkbox"/> Isolating from others<br><input type="checkbox"/> Panic attacks<br><br><input type="checkbox"/> Excessive worry<br><input type="checkbox"/> Parent/Child relationship problems<br><input type="checkbox"/> Nightmares<br><input type="checkbox"/> Irritability<br><input type="checkbox"/> Hopelessness<br><input type="checkbox"/> Relational Difficulties<br><input type="checkbox"/> Increased Alcohol Use | <input type="checkbox"/> Anger or Rage<br><input type="checkbox"/> Insomnia – decreased need for sleep<br><input type="checkbox"/> Feelings of loneliness<br><br><div style="border: 1px solid black; padding: 2px;"> <input type="checkbox"/> Thoughts of hurting others<br/> <input type="checkbox"/> Thoughts of death or Suicide         </div> <input type="checkbox"/> Abuse of prescription drugs<br><input type="checkbox"/> Eating problems<br><br><input type="checkbox"/> Low self worth<br><input type="checkbox"/> Sexual Compulsions<br><input type="checkbox"/> Obsessive Thoughts<br><input type="checkbox"/> Present drug or alcohol abuse |
|--|--|---|

Other Symptoms \_\_\_\_\_

How long have the above symptoms been present? \_\_\_\_\_

When did they start getting worse? \_\_\_\_\_

What is your chief concern at this time? \_\_\_\_\_

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When would you estimate the above concerns began?

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What stressful events have recently occurred in your life?

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Are you presently seeing a counselor or other health professional concerning your issues?

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Do you have a supportive family or spiritual community? Please briefly explain.

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## CLIENT INFORMATION AND CONSENT FORM

### THERAPIST

John Wilson is a Licensed Professional Counselor working as an independent contractor. Although Allen Counseling Associates may refer you to me, or I may refer certain situations to them, I am not associated with them. **If you are currently seeing another therapist/counselor, you need to let me know this before or during the first session.**

### INDIVIDUAL COST – PRIVATE PAY CLIENTS

The cost for the initial 60 to 90 minute session and assessment is \$100.00. All sessions after the initial assessment are usually 40 to 50 minute in length and cost \$85.00 per session. Anything over 60 minutes is prorated at \$85.00 an hour. Payment is expected at the time of service. Payment can be made in the form of cash or a personal check. There is a \$25.00 return check policy. The fees for career assessments are as follows: the Campbell Interest and Skills Survey -\$40.00. The Self-Directed Search - \$25.00. For example, the charge for the counseling session plus feedback on the Campbell Survey will be \$125.00.

Sessions will be discontinued if an outstanding balance develops without the establishment of payment arrangements. Any service beyond the normal counseling sessions will be charged \$150.00 an hour on a prorated basis. These services may include, but are not limited to the following: report writing, preparation of records or treatment summaries, or the time required performing any other service that you may request of me. If you become involved in litigation that requires my participation including but not limited to divorce, custody disputes, or cases involving CPS, I charge \$150 per hour for preparation for and attendance at any legal proceedings. In addition, a \$500 retainer will be required up front if court appearances occur.

### CLIENTS USING INSURANCE OR EMPLOYEE ASSISTANCE PROGRAMS

Insurance Providers and Employee Assistance Programs vary in their charges. Some plans require a co-payment while others do not. It is best that you contact your insurance company to see if they will cover some or all of your counseling. Please ask if you have met your deductible and if you have a co-pay amount. This is why it is very important to understand what your insurance does and does not cover. Some plans may have medical benefits but not behavioral health coverage. Some behavioral health plans may pay for individual, but not marital counseling. If you have questions about your fees or benefits, I suggest that you call your insurance carrier and clarify things. You are ultimately responsible for the cost of counseling. I will be glad to call and confirm your understanding of your plan.

### APPOINTMENTS

Appointments are made by calling (972) 838-6290. Most of my appointment openings are between 3:00 and 8:00 pm on Monday, Wednesday, and Thursday. Saturday appointments are sometimes available for special situations usually between 2:00 and 6:00 p.m. If you leave a message, please provide a phone number where I can contact you. Typically, appointments are made one week ahead of time.

### CANCELLATIONS

Cancellations should be received at least 24 hours before your scheduled appointment. You are responsible for calling to cancel or reschedule your appointments. Someone else could want the time slot you schedule; therefore, it is important to keep your appointments. I do understand that unexpected situations sometimes arise, but consistent failure to attend scheduled counseling sessions could result in termination of counseling.

## **AFTER HOUR EMERGENCIES**

My services should not be used in emergencies. Emergencies are urgent issues requiring immediate attention. If you encounter an emergency that requires immediate attention, please call 911 or go to the emergency room of your choice. You can leave a message with me after contacting your physician, the emergency room of your choice, or a licensed mental health facility.

## **RELEASE OF RECORDS**

The laws and standards of my profession require that I keep appropriate treatment records. You are entitled to receive a copy of the records in most situations. Because these are professional records, they can be misinterpreted and/or upsetting. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged a \$100 an hour fee times the number of hours required to comply with any information request for records. I also ask that you give me at least a weeks notice if you wish to review your records with me. In the case of my death or incapacity to counsel, your records will be left with Michelle Nietert at Allen Counseling Associates.

## **BENEFITS AND RISK OF THERAPY**

While benefits are expected from counseling, no specific outcomes can be guaranteed. Part of the counseling process deals with establishing goals and a plan for reaching them. Your time in counseling may lead to major changes in how you choose to view important issues in your life. During the counseling process, there may be periods of increased discomfort and strong feelings. The objective is to work through these feelings and to reach an outcome based on your goals for counseling. Regarding spirituality issues, as a Christian, I believe that one's relationship with God can play an important role in the counseling process. If you would like to involve God and prayer in the counseling process, please share this with me.

Our first session will involve an evaluation of your needs. After the first session, I will be able to offer you some initial impressions and a treatment plan to follow if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If at anytime, you feel that the issues discussed have not been resolved to your satisfaction, I will be happy to help you find or consult with another therapist.

## **EXCEPTIONS TO CONFIDENTIALITY**

In general, the confidentiality of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written permission. However, there are a number of exceptions including some legal proceedings and laws that govern the protection of others. These exceptions include, but are not limited to the following:

1. I determine that you are a danger to yourself or others. This may include physical restraint from self-harm and requesting emergency assistance and transportation to a medical or psychiatric facility.
2. If you admit to AIDS/HIV infection and state that you are engaged in sexual practices that endanger the life of others and have not warned them about the possibility of AIDS/HIV transmission.
3. You disclose abuse or neglect of a child, an elderly or disabled person.
4. You disclose sexual contact with another therapist or mental health professional.
5. I am ordered by a court or required by law to disclose information.
6. You direct me to release your records. A Release of Information form will be used for this purpose.
7. Your insurance or third party payer requests information to authorize coverage of services.

It should also be understood that in some situations I may find it helpful to seek the opinion of another professional in my field. In such situations, your name and other identifiers will be kept out of the conversation. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns now or at our next meeting. The laws governing these issues are quite complex, and I am not an attorney. While I am happy to discuss these issues with you, should you need specific advice about an issue, formal legal consultation may be desirable.

**CLIENT RIGHTS**

1. You have the right to considerate and respectful treatment, regardless of age, race, sex, national origin, citizenship, or legal status.
2. You have the right to be informed about any counseling fees.
3. You have the right to know that your records are confidential and cannot be released without your consent, except under the reasons stated in the section named Exceptions to Confidentiality.
4. You have the right to get complete and current information regarding your treatment plan.
5. You have the right to refuse treatment, except when limited by court order.
6. You have the right to a written Individual Treatment Plan, as well as the right to participate in the preparation of the plan.

If you have a complaint about the way you have been treated or the services I offer, please feel free to discuss this with me. I want to offer you the best services possible and treat you with dignity and respect. If after talking to me your situation is still unresolved, you do have the right to call the Texas State Board of Examiners of Professional Counselors at (512) 834-6658.

**CLIENT RESPONSIBILITIES**

1. I understand and agree to the fees for counseling as discussed above.
2. I will keep the appointment time, or will call to cancel at least 24 hours in advance.
3. I understand that confidentiality cannot be guaranteed in all cases. I understand the exceptions to confidentiality as stated above.
4. I understand that in an emergency where I am an immediate threat to others or myself I will call 911.

**DUTY TO WARN**

In the event that a situation arises where I believe you are a serious threat to yourself or others, I am obligated to contact the pertinent authorities in order to ensure the safety of you and all parties involved. In addition to medical and law enforcement personnel, please list one or two people that I may contact in an emergency situation:

Name

Phone

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**REFERRALS**

In certain situations, there could be times that I refer you to other professionals to provide services that will enhance our work. If at any time you and/or I believe that a referral to another counselor or mental health professional is needed, I will provide you with the names of other professionals who may assist you. You will be responsible for contacting and evaluating those referrals. With the exception of emergencies, I will need your written permission to contact other counselors or other mental health professionals.

**DIAGNOSIS**

It should be noted that a diagnosis is required if you are paying for treatment via your insurance company. Put simply, I am required to submit a diagnosis when I bill the insurance company. If you already have a diagnosis from a doctor or other professional please let me know. Most EAPs and some behavioral health plans do cover minor behavioral health issues while other may not cover this. Please ask me and/or your insurance company if you have questions about this.

**CONSENT TO TREATMENT**

By signing this Counseling Contract and Consent Form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. This includes Exceptions to Confidentiality and Duty to Warn. I also acknowledge that any questions regarding the Information and Consent Form have been answered to my satisfaction. Lastly, I agree to accept and abide by all the terms stated in this Counseling Contract and Consent Form.

(Signed) \_\_\_\_\_

Date: \_\_\_\_\_

(Signed) \_\_\_\_\_

Date: \_\_\_\_\_

(Signed) \_\_\_\_\_

Date: \_\_\_\_\_

(Therapist) \_\_\_\_\_

Date: \_\_\_\_\_

**John Wilson - Licensed Professional Counselor**

1506 N. Greenville Ave, Suite 200, Allen, TX 75002

**Notice of Policies and Practices to Protect the Privacy of Your Health Information**

*THIS NOTICE DESCRIBES HOW COUNSELING AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.*

*PLEASE REVIEW IT CAREFULLY.*

**I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”
  - Treatment is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  - Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

**II. Uses and Disclosures Requiring Authorization**

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information. we will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

**III. Uses and Disclosures with Neither Consent nor Authorization**

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.

- **Health Oversight:** If a complaint is filed against one of our counselors with the State Board of Licensed Professional Counselors, the Board has the authority to subpoena confidential mental health information from us relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If it is determined that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

#### **IV. Patient's Rights and Counselor's Duties**

##### **Patient's Rights:**

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at this office. Upon your request, we will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your access to PHI may be denied under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have provided neither consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

##### **Counselor's Duties:**

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will inform you of such changes.

#### **V. Complaints**

If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may contact John Wilson at 972-838-6290. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

#### **VI. Effective Date, Restrictions and Changes to Privacy Policy**

This notice will go into effect on April 14, 2003.