PM

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:

____

Group or Policy Number if applicable ______________________

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 the accuracy of the information listed above.

_________________________________ _________________________________
Signature Date

_________________________________ _________________________________
Therapist Signature Date

CURRENT HEALTH STATUS

We will not attempt to contact any physician or psychiatrist without your consent unless it is an emergency. There are a lot of people who are taking antidepressants or some other type of medication that their doctor has prescribed. The reason we ask about your current health status is to know how to best help you.

Name or your present family physician ___________________________________

Phone Number __________________

Month and year of last doctor s visit _____________

Name of Medication you currently use:

____

____

____

Name of psychiatrist (if any) _______________________________

Phone number __________________

Month and year of last visit with psychiatrist __________________

Reason(s) you are seeing a psychiatrist ____

Are you currently taking medication to help you with depression, anxiety, insomnia, bipolar, or other problems? If so, please list the medications that you are taking?

____

____

Have you ever been hospitalized for any psychiatric related illness? Yes _____ No ______

If so, what date or dates were you hospitalized? __________________________________

Symptoms and Issues Checklist

Patient Name: ____Date: _____________

Even though you are primarily seeking premarital counseling, we have found that it is very helpful to understand and recognize other symptoms that you may be experiencing. Please put a check next to any symptoms that you have experienced in the last six months. Many people experience some of the symptoms below at different times in their life. Your honesty will help me best know how to help you.

___	Depressed Mood	___	Crying Spells	___	Relational Difficulties
___	Increased Anxiety	___	Changes in appetite	___	Anger or Rage
___	Mood Swings	___	Insomnia – inability to sleep	___	Insomnia – decreased need for sleep
___	Poor concentration	___	Isolating from others	___	Feelings of loneliness
___	Sleeping too much	___	Panic attacks	___	Thoughts of hurting self or others
___	Grief over a loss	___	Excessive worry	___	Abuse of prescription drugs
___	Difficulty with memory	___	Parent/Child relationship problems	___	Hopelessness
___	Specific fears or phobias	___	Nightmares	___	Eating problems
___	Impulsivity	___	Irritability	___	Low self worth
___	Hallucinations	___	Self injurious behavior	___	Sexual Compulsions
___	Marital problems	___	Thoughts of death or Suicide	___	Obsessive Thoughts
___	Past drug or alcohol abuse	___	Increased Alcohol Use	___	Present drug or alcohol abuse

Other Symptoms ____

What specific issues would you like to address in premarital counseling?

____

____

____

What stressful events (if any) have recently occurred in your relationship?

____

____

____

____

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

____

____

____

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

____

____

____

Issues checklist:

Listed below are several issues that are common in relationships. Your honesty will help me to know how to help you.

Please give each listed issue a score between 0 and 3.

0 = you do not see this as an issue in your relationship
1 = an issue but not an important issue as you see it
2 = a moderate issue in your relationship
3 = a major issue as you see it in your relationship
X= You have not discussed or had to deal with this issue

____ Communications
____ Respect
____ Love and affection
____ Unresolved feelings or anger over past issues or certain situations
____ Issues with discipline in regards to children or stepchildren
____ Name calling or making derogatory remarks towards each other
____ Sexual issues
____ financial issues
____ Religious or denominational issues
____ Issues regarding spirituality
____ Need to spend more time together
____ Depression or anxiety
____ Issues with in-laws
____ Alcohol or drug use
____ Sharing responsibilities
____ Issues surrounding commitment
____ Shared Goals and Values

Please put an **A** in front of the issues that you think you both agree on and a **D** in front of issues that you do not agree on. If you have not discussed the stated issue or you are unsure if you both are in agreement on this issue put an **X** in front of the statement.

A – (Agree) - we have discussed this issue and are in agreement about it
D – (Disagree) – we have discussed this issue and have some disagreements about it.
X – I am unsure if there is agreement about this issue or we have not discussed it

____ Who will handle the finances
____ Whether or not you will belong to a particular religious denomination
____ How many children you want
____ How you will discipline your children
____ Attitudes and feelings towards alcohol use
____ Issues regarding in-laws.
____ How to respond to one another in the middle of a conflict or disagreement
____ Acceptable and unacceptable sexual practices in your marital relationship
____ Long-term goals as a couple
____ How much time each of you will individually spend in activities outside the marriage.
____ Who will do the housework like washing dishes, cleaning, and cooking.
____ Your ideas about your spouse remaining friends with people he/she once dated.
____ Your thoughts about your spouse having friends of the opposite sex.
____ Where you will spend important family holidays like Thanksgiving or Christmas.
____ Your views about commitment in a marriage relationship and what that means.
____ How you will use your vacation time
____ The role spirituality or your faith will play a role in your marriage.
____ The role of recreational drugs in your marriage

Please put a **Y** for yes or **N** for no in front of each statement. Put **NS** for Not sure.

____ We have discussed what expectations we have of one another in our marriage.
____ We have made a list or verbally discussed the things that we must have in a marriage.
____ We have made a list of things that we will not tolerate in a marriage
____ I am accepting of my fiancés friends and have no concerns about their continuing to spend time together.
____ My extended family and relatives are very accepting of my fiancé and our marriage.
____ We have discussed what would happen should one of us become ill and could not work.

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.

PREMARITAL COUNSELING COST

The cost for the initial 60 to 90 minute session and assessment is $100.00. The cost for a 45 to 60 minute session is $85.00. 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. Sessions will be discontinued if an outstanding balance develops without the establishment of payment arrangements. There is a $25.00 return check policy. Any service beyond the normal counseling sessions will be charged $100.00 on a prorated basis for additional time in session and for other professional services, you may require. These services may include, but are not limited to the following: report writing, telephone conversations that last longer than 10 minutes, preparation of records or treatment summaries, or the time required to perform 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 the counseling relationship.

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. (Most insurance companies require that a therapist submit a diagnosis, summary of symptoms, and treatment plan in order to authorize services.)
8. You and your boyfriend/girlfriend are in premarital counseling. The general rule is that I do not keep secrets. It is just too hard to keep track of what should and should not be shared.

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

____

____

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.

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: ________________

(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.