Melanie Smith, M.A, L.P.C
2217 North Park Avenue Pearland, Texas 77581
Phone: 281-997-8400 Fax: 281-997-8408
RDI® Program Certified Consultant
www.pearlandcounselingcenter.com

Adult

I am excited about meeting with you at Pearland Counseling Center!! Please take the time to fill out the information below to help us cater the assessment to your needs as much as possible.

OFFICE INFORMATION AND POLICIES

I am pleased that you have selected me as your Counselor. This document is designed to inform you of my background and to ensure you understand our professional relationship. I am a Licensed Professional Counselor with training in working with children, adolescents, and adults.

Goals of Therapy: Counseling is a process whereby the Counselor helps you to help yourself with the problems you are experiencing. Together, you and the Counselor assess your problems and establish goals for counseling. Your Counselor will not make decisions for you, but will facilitate you reaching your goal. Counseling may be beneficial for most people while at the same time there are risks. The risks may include the experience of intense feelings, which may include sadness, anger, fear, guilt, or anxiety. It is important to remember that these feelings may be natural and normal part of the counseling process.

Length of Counseling: Each client will have different issues to address in counseling so there is no set number of sessions you will need to attend. You and I Counselor will decide as you progress how often you should attend counseling. Termination of counseling may happen at any time and may be ended by you or your Counselor.

Dependent Clients: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will require that person to provide legal paperwork stating that this person has this authority and can act for you before we take any action. If a parent or guardian of a child under 18 request services, we need permission to counsel that child. The parent of legal guardian will be asked to sign a form that gives the Counselor permission. It is important that the child trust the Counselor. A parent or legal guardian has the right and responsibility to question and understand the nature and progress of the counseling and the Counselor must use her clinical discretion as to what is appropriate disclosure. While the Counselor may not tell you specific information your child provides, the Counselor will discuss your child's participation and progress in treatment.

Appointments and Messages: Calls are recorded by a confidential voice mail system and are returned as soon as possible. To facilitate this, the caller needs to leave a daytime/evening phone, cell, or pager number along with current concerns. My cell number is: 281-804-7915 if you need to reach me in an emergency. The counseling service is by appointment only. The length of the counseling session is usually 45-50 minutes, or what is known as a clinical hour. Because an appointment is reserved for you, it is required that you let us know by 1:00 pm the day prior to your appointment if you must cancel or reschedule your appointment.

******You are financially responsible for the session missed unless you have given the proper notice. No show or No call is a fee of $50.00.******

Fees: The standard fee for a 45-50 minute psychotherapy session is $125.00 and longer sessions pro-rated accordingly. If you are using your insurance, there are different contracted amounts for each managed care company. Please provide the administrative staff with your insurance information. For a copy of clinical records, there is an administrative fee of $25.00 for the first twenty pages and 50¢ for each page thereafter along with a reasonable fee for the cost of mailing, shipping, or delivery. If you, (the client), becomes involved in legal proceedings that require my participation, you will be expected to pay for my professional time, including preparation and my travel cost, even if I am called to testify by another party. You will also be responsible for my legal representation fees. The charge is $400/hour for my involvement in any legal proceedings. If I am required to go to court to testify, you agree to pay 24 hours in advance.

The cost of this is $1600.00 for a half day, from 8:00am-12:00pm, or $3200.00 for a full day. After six months, these fees may increase and is not covered by insurance.

I, Melanie Smith, reserve the right to notify the police or person if you share any indication of harming someone.

I, Melanie Smith, reserve the right to notify the police or appropriate authorities if you share any indication of harming yourself.

Filing w/Insurance: We file with your insurance company as a courtesy to you. You are responsible for all charges that are not paid by your insurance company.

Confidentiality and Client's Right: Clients are assured that confidentiality is protected by ethical practice and the laws of the State of Texas. There are few exceptions to confidentiality that are legally mandated. In general terms they include:

1. A requirement to notify relevant others if a client has any intentions to harm another person or themselves
2. A requirement to report any incidence of suspected child and/ or elder abuse or neglect
3. To file insurance or work with a managed care company, information regarding your treatment, diagnosis, prognosis and the specific issue for which you have come t treatment are available to the insurance or managed care company. We make every effort to release only the minimum information about you that is necessary for the purpose requested. Once this information is turned over to the insurance, managed care company, or requesting entity, the Counselor has no control over how the information is to be used.*

Records Request: We make every effort to keep your mental health records secure per HIPAA (Health Insurance Portability and Accountability Act) and the Texas Health and Safety Code regulations.

To request a copy of your (the clients) mental health records:

1) Request a copy of your mental health records/documents in writing. If you mail your request, address the request to your therapist at 2217 N. Park Avenue, Pearland, TX 77581. Please print and sign your name on the request.
2) Please be aware your request for a copy of your records or a copy of documents from your records can be denied.
3) Your therapist has up to 15 days after receipt of your request to provide the requested documents or provide a denial of the request.
4) There may be a fee charged for the requested mental health records/documents.

Complaint Process:

An individual who wishes to file a complaint against a Licensed Professional Counselor may write to:

Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369
1-800-942-5540

I look forward to being of service to you and encourage you to participate actively and to stay informed about your counseling process.

*Please see "Notice of Privacy Practices" brief version for additional information located in your introduction packet. A long version of the Notice of Privacy Practices is available upon request and is also posted in the waiting room.

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Upon complete review of all documents in this packet, pages 1-12, your therapist will provide an Acknowledgement and Consent form to be signed by you (the client) and your therapist during the initial session.

I (the client) understand that pages 1-12 (Excluding Signature Page, page 3) of this packet are available to me anytime online at www.pearlandcounselingcenter.com or by request. This request can be made in person at Pearland Counseling Center, 2217 North Park Avenue, Pearland, Texas 77581.

I (the client) understand that my signature is required on the Acknowledgement and Consent form before services can be provided. I (the client) understand that **if I choose NOT to sign the Acknowledgement and Consent form counseling services will NOT be provided.**

IMPORTANT: It is required the Acknowledgement and Consent form is signed by you (the client) and witnessed prior to the start of counseling services.

CLIENT REGISTRATION PAGE

TODAY'S DATE: _____

Patient Name: _____ DOB: __ __ - __ __ - __ __ __ __ Age: ___ Gender: ___

Marital Status: **SINGLE MARRIED DIVORCED WIDOWED** SS#: __ __ __ - __ __ - __ __ __ __ DL#: __ __ __ __ __ __ __ __ __

Address: _____ APT#: _____

City: _____ State: _____ Zip: _____

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

May we contact your home #? _____ May we contact your work #? _____ May we contact your cell #? _____

May we leave a message? Y N May we leave a message? Y N May we leave a message? Y N

E-Mail Address: _____

Employer: _____ Occupation: _____

Emergency Contact

Name: _____ Relationship: _____

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

Name of person responsible for this client: _____ Relationship: _____

INSURANCE INFORMATION

Name of Insured person: _____ Relationship: _____

Insured SS#: __ __ __ - __ __ - __ __ __ __ Insured DOB: __ __ - __ __ - __ __ __ __ Gender: _____

Insured Employer: _____ Employer Phone #: __ __ __ - __ __ __ - __ __ __ __

Name of Insurance: _____ Ins. Phone #: __ __ __ - __ __ __ - __ __ __ __

ID or Policy #: _____ Group #: _____

ADDRESS AND CONTACT INFORMATION OF INSURED PERSON, *IF NOT THE SAME AS CLIENT*

Address: _____ APT#:_____

City: _____ State: _____ Zip: __ __ __ __ __

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

MEDICAL HISTORY

Reason for seeking Counseling: _____

_____

Other physicians treating you: _____ Phone #: __ __ __ - __ __ __ - __ __ __ __

Other physicians treating you: _____ Phone #: __ __ __ - __ __ __ - __ __ __ __

Other physicians treating you: _____ Phone #: __ __ __ - __ __ __ - __ __ __ __

Current physical problems (describe): _____

_____

Current Medications: _____

_____

NOTICE OF PRIVACY PRACTICES – BRIEF VERSION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

- Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required NPP which is available upon your request and contains more information regarding your protected health information. Please talk to your Privacy Officer (see the end of this pamphlet) about any questions or problems.
- We will use the information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.
- If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this.
- Of course we will keep your health information private but there are some times when the laws require us to use or share it.

For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public.
   We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Your Rights Regarding Your Health Information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records but we may charge you. We will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another within 12 months. Contact your Privacy Officer to arrange how to see your records. See below.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to your Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy of the NPP from your Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with your Privacy Officer Melanie Smith, M.A., LPC, NCC at 2217 North Park Avenue, Pearland, TX 77581. All complaints to our Privacy Officer must be in writing. You can also file a complaint with the Secretary of the Department of Health and Human Services Office for Civil Rights at 200 Independence Ave., S.W. Washington, D.C. 20201, or by calling 1-877-696-6775 or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact your Privacy Officer who is Melanie Smith, M.A., LPC, NCC and can be reached by phone at (281) 997-8400.

The effective date of this notice is September 22, 2014

Acknowledgement of Receipt of Notice of Privacy Practice

I, _____, have read and understand this document. I recognize that I have the opportunity now and in the future to discuss any question I may have with my counselor. I agree to the practices and policies delineated herein and have received a copy of this Office's Notice of Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

It is your right to refuse to sign this document

For Office Use Only:

The reason that a standard acknowledgment (such as the above) of the receipt of the Notice of Privacy Practices was not obtained:

_____ Patient refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented this office from obtaining it.

_____ Others: _____

Email and Texting Consent

HIPAA regulations and my professional Code of Ethics both require that I keep your Protected Health Information private and secure, and indeed I want to do so. Email is a very convenient way to handle administrative issues like scheduling or receipt requests, but email is not 100% secure. Some of the potential risks you might encounter if we email include:

- Misdelivery of email to an incorrectly typed address.
- Email accounts can be 'hacked,' giving a 3rd party access to email content and addresses.
- Email providers (i.e., Gmail, Comcast, and Yahoo) keep a copy of each email on their servers, where it might be accessible to employees, etc.

For these reasons, I will not use email to discuss clinical issues (i.e., the important things we talk about in session.)

If you are comfortable doing so, I am happy to use email to handle small administrative matters like scheduling and billing. This will only be utilized if the Office Staff is unavailable to assist you with these matters.

The Office Staff will handle all scheduling, billing and other office matters by phone only. Email and text will not be used as a form of communication. If this policy changes, you will be notified at the time of change and be provided with an updated consent to review and sign.

If you are not comfortable with these risks, we can handle administrative issues via phone calls.

I do not text clients appointment confirmations.

Please indicate your preference about email below and sign. **(CIRCLE ONE)**

I DO or DO NOT consent to use email for administrative matters.

If given, consent will expire 2 years after our last appointment. This means that I will not initiate contact via email, although you are always still welcome to email me, and I can reply briefly if you do.

Printed Name: _____

Signature: _____ Date: _____

POLICY FOR NO SHOW/LATE CANCEL AND OUTSTANDING BALANCE DUE

We are very committed to serving our clients and strive to accommodate all of our clients by making appointments available as soon as possible.

When an appointment is reserved for you, we require that the appointment be cancelled by **1:00 pm the day prior to the appointment.** We understand that emergencies happen, and we will be happy to work with you in those situations. If you have any questions, please feel free to speak with our office manager.

****

I understand that I will be responsible for a **missed appointment fee of $50.00** and that my credit card will be charged if I am unable to provide the proper notice that I will not keep my scheduled appointment. Note: This policy may also apply to sessions provided by Employee Assistance Programs (EAP).

I also understand that I will be responsible for any outstanding balance for services rendered and that my credit card will be charged to pay for the outstanding balance.

If you choose to provide your flexible spending account information, an additional credit or debit card number is required as the situation may occur that your flex account holds insufficient funds or its balance has become depleted.

We accept the following debit/credit cards: Visa, Discover, American Express and MasterCard.

FOR FLEX CARD:

Name As Appears On Card: _____

Credit Card Number: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Expiration Date: _____

FOR CREDIT/DEBIT CARD:

Name As Appears On Card: _____

Credit Card Number: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Expiration Date: _____

I have read, understand and agree to the Policy above and give my permission for my card to be charged if a violation occurs.

Print Name: _____

Signature: _____ Date: _____

I _____ (CREDIT CARD HOLDER NAME) understand that by providing my Credit Card information I am consenting to being financially responsible for

_____ (CLIENT NAME) regarding any violation of the Policy stated above.

Print Name: _____

Signature: _____ Date: _____

You may revoke this consent at any point, by submitting a request in writing which MUST include:
Date of request, client's name, your name, signature, copy of your current Driver's License, and an explanation of the information to be removed. If you are mailing your request, please keep in mind there could be charges to your card until your request is received by our office.

OFFICE USE ONLY: DATE OF REVOKE REQUEST _____ DATE REQUEST REC'D (EFF. DATE OF REVOKE) _____

SOCIAL MEDIA

Social media is used for personal use only and should not be used in professional relationships. In order to respect the boundaries of both the clients and the staff, including maintaining confidentiality, there can be no affiliation on these websites.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client's Initials: _____

INSURANCE – ASSIGNMENT AND RELEASE

I the undersigned certify that I (and/or my dependents) have insurance coverage with _____ and that I assign directly to Melanie Smith, M.A., LPC, NCC all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize Melanie Smith, M.A., LPC, NCC to release any information necessary to secure payment of benefits. I authorize this signature on all insurance submissions.

Client's Initials: _____

POLICY FOR PROVIDING NEW INSURANCE INFORMATION

Our clients are very important to us and our main goal is make their time here as pleasant and smooth as possible. It is pertinent that we receive any updated information prior to your scheduled appointment so that we are able to avoid any discrepancies with your insurance coverage.

If/when you acquire new insurance, we require a 48 HOUR NOTICE prior to your scheduled appointment. If you do not provide your updated insurance information within the 48 hour timeframe you will be subject to a fee. The fee will be based on the contracted rate of your insurance company.

I understand that I will be responsible for any fees and/or balances owed on my account if I do not provide my new insurance information within the required time period. This includes claims that are denied.

Client's Initials: _____

Print Name: _____

Signature: _____ Date: _____

Adult Client Questionnaire

If you will be self-pay what is your average yearly income: _____

How many marriages? _____ How many years married? _____, _____, _____

Children's ages and genders:

Child One: AGE _____ GENDER _____ Child Two: AGE _____ GENDER _____

Child Three: AGE _____ GENDER _____ Child Four: AGE _____ GENDER _____

Stepchildren's ages and genders:

Step -Child One: AGE _____ GENDER _____ Step-Child Two: AGE _____ GENDER _____

Step-Child Three: AGE _____ GENDER _____ Step-Child Four: AGE _____ GENDER _____

Have you ever been hit, kicked, punched or otherwise hurt by someone within the past year? Y N

If so, by whom? _____

Do you feel unsafe in your current relationship? Y N

Is there a partner from a previous relationship who is making you feel unsafe now? Y N

Health History

Do you smoke cigarettes? Y N If so, how many cigarettes per day? _____

Do you drink alcohol? Y N If so, how many drinks per week? _____

Have you ever felt you ought to cut down on your drinking? Y N

Have people annoyed you by criticizing your drinking? Y N

Have you ever felt bad or guilty about your drinking? Y N

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Y N

What is happening in your life which resulted in this appointment? _____

_____

What would you like to see accomplished in therapy? _____

_____

Have you ever been hospitalized for psychiatric issues? Y N

If so, where and when? _____

_____

Have you ever been in therapy before? Y N

If so, where and when? _____

_____

Do you have any current diagnosis (es)? Y N?

If so, what is your diagnosis (es)? _____

_____

Concerns:

Please check any items below that apply and give a brief explanation below:

- ☐ I have no problem or concern bringing me here
- ☐ Abuse—physical, sexual, emotional, neglect
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Custody of children
- ☐ Childhood issues (your own childhood)
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription, OTC medications, street drugs
- ☐ Eating problems—overeating, under eating, purging, etc.
- ☐ Fatigue, tiredness, low energy
- ☐ Financial or money troubles
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Health, illness, medical concerns, physical problems
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Loneliness
- ☐ Marital conflict, distance, infidelity/affairs
- ☐ Mood swings
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (repetitive thoughts or actions)
- ☐ Panic or anxiety attacks
- ☐ Parenting, child management, single parenthood
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems (with friends, relatives, or coworkers)
- ☐ Remarriage
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences
- ☐ Spiritual, religious, moral, ethical issues
- ☐ Stress
- ☐ Suspiciousness, distrust
- ☐ Suicidal thoughts
- ☐ Temper problems
- ☐ Threats, violence
- ☐ Withdrawing or isolating from others
- ☐ Work problem
- ☐ Other concerns or issues:

_____
_____
_____
_____

Please check any of the following that describe you and explain below:

- ☐ I am unable to do the things I used to do
- ☐ I feel sluggish/restless.
- ☐ I get tired for no reason
- ☐ I feel unhappy.
- ☐ I think about killing myself
- ☐ I can't make decisions.
- ☐ I am gaining/losing weight
- ☐ I am sleeping too little (or too much).
- ☐ I feel hopeless about the future.
- ☐ I am often anxious
- ☐ I am often misunderstand people

Please look back over the concerns you have checked off and choose the three that you are most concerned with.

In order of importance, they are:

1. _____
2. _____
3. _____

Who can I thank for referring you to me? _____