Dawn Nelson, LCSW-S, ACSW, SAP, CART

Patient Information

Name: _____ Phone: _____ MALE FEMALE
Is it ok to leave call/leave message/text appointment reminders? Y N

If couples counseling, additional Client's Name:_____ MALE FEMALE

Address: _____City: _____ State: ____ Zip: _____
E-mail Address: _____
(NEVER shared or sold); Okay to email for appointment reminders? Y N

Age: _____ Birth Date: _____ Marital: S M W D Other

If couples counseling, additional client's Age: _____ Birth Date: _____

Name of Emergency Contact: _____Phone: _____

How were your referred to my office?

____ Psychology Today

____ Google

____ My Website

____ Good Therapy

____ Other: _____

Family Medical Doctor (first and last name):
_____
Month and year of last physical: _____

Current Psychiatrist or Other Health Specialist:
_____
Month and year last seen: _____ When healthcare professionals work together it benefits you. Do I have your permission to update your medical doctor regarding your care? YES NO WISH TO DISCUSS MORE _____Initial Here

Purpose of today's appointment:
_____
_____
_____

Previous counseling? ____ Yes ____ No If yes, when and was it helpful:
_____
_____
_____

Current Medications and Dosage:
_____
_____
_____

Previous Medications:
_____
_____
_____

AUTHORIZATION AND RELEASE: I authorize the therapist to release all information necessary to communicate with personal physicians (unless otherwise noted), and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE.

Patient's Signature: _____ Date: _____

Co-patient Signature (if seen together): _____ Date: _____

Parent/Guardian's Signature Authorizing Care: _____
Date: _____

Informed Consent for Counseling

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CONFIDENTIALITY: Everything you say in these sessions and the written notes I take are confidential and may not be released to anyone without your written permission except where disclosure is required legally. **_____ Initial**

WHEN DISCLOSURE IS REQUIRED BY LAW: Disclosure is required or may be required by law **when there is a reasonable suspicion of abuse or neglect of a child, elder, or disabled person or where a patient presents a danger to self or others**. **_____Initial**

DISCLOSURE MAY ALSO BE REQUIRED BY THE COURT. I will not voluntarily release records to any third party unless I am authorized to do so by all adult parties whom were part of the family therapy, couple therapy or other treatment that involved more than one adult patient. However, a judge may issue a court-order requiring the involuntary release of records. You will be informed before release is made. **_____ Initial**

EMERGENCY: If there is an emergency during therapy or after therapy, and I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet. **_____ Initial**

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: We recommend you not use insurance, however, if you choose to file, disclosure of confidential information may be required by your health insurance carrier or other third-party payer in order to process the claims. Only the minimum necessary information is communicated to the carrier. **_____ Initial**

RECORDS AND YOUR RIGHT TO REVIEW THEM: The law requires that I keep treatment records for 5 years. As a patient, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I feel that releasing such information might be harmful in any way. Upon your request, I will release information to any qualified medical personnel you specify. When more than one patient is

involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults involved in the treatment. **_____ Initial**

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please call. If I do not answer, I will return your call as soon as possible. If an emergency situation arises, call 911 or go to your nearest emergency room. **_____ Initial**

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Therapy can affect you in many ways. You may resolve the problem you came in for, but it takes effort on your part. You must be open and honest. We may also talk about unpleasant events which may cause you discomfort and I may challenge some of your ways of thinking. You must also know that while we fully expect change, there is no promise that this therapy will yield a positive result. Change will sometimes be easy and swift, but sometimes it will be slow and even frustrating. I am likely to draw on various psychological approaches. These approaches may include: behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. I do not prescribe medications but will work in conjunction with physicians whom do. **_____ Initial**

TREATMENT PLANS: At the end of our initial session, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy or about the treatment plan, please ask. You also have the right to ask about other treatments for your condition and their risks and benefits. Reports generated for academic and other planning also require additional fees.

_____ Initial

TERMINATION: After the first meeting, I will assess if I can be of benefit to you. I do not accept patients whom, in my opinion, I cannot help. In that case, I will give you a referral whom you can contact. If at any point during therapy you are non-compliant, I will discuss the situation with you and may terminate treatment. In such a case, I will give you a licensed provider referral that may be of help to you. Upon your request, I will provide them with the essential information needed. You have the right to terminate therapy at any time. **_____Initial**

COURT TESTIMONY: I understand that the therapist is not trained in expert testimony. I understand that additional fees are payable before court appearances and depositions should the therapist be required to testify for court. Meetings and reports generated for the courts also require additional fees.

_____Initial

DUTY TO WARN: Receiving counseling from a licensed professional is a confidential process. Your identity will not be revealed to anyone without your consent, HOWEVER: some courts have held that if a client intends to take harmful or dangerous action against another human being or against him/herself, a therapist has a Duty to Warn the intended victim and or state/local law enforcement. In cases of suspected child or elder abuse, I am required to notify appropriate state agencies. If you become involved in legal action, a court of law may subpoena my testimony or your records. I will, when expedient, notify you of these actions if they become necessary. **_____ Initial**

SOCIAL NETWORKING AND INTERNET SEARCHES: To protect client confidentiality, I do not accept friend requests from current or former patients on social networking sites, such as Facebook. For this same reason, patients may not communicate with me via any interactive or social networking web sites. **_____ Initial**

In the event of my death or incapacity, your records will be managed by the Texas State Board of Social Work Examiners.

Texas State Board of Examiners of Social Work Examiners

8407 Wall St, Austin, TX 78754
(512) 719-3521

I have read the above policies. I understand them and agree to comply.

Client's Signature _____ Date _____

Co-Client's Signature (if applicable)_____ Date_____

Therapist's Signature _____Date _____

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Financial Information and Agreement

1. The fee for counseling is as follows: **Individual Therapy 50-minute Sessions, $160.00**
Couples/Family 50-minute Sessions, $170.00
Ask for Rates of Other Services

POLICIES AND PAYMENT:

APPOINTMENTS: Your appointment time is reserved exclusively for you. Appointments cancelled with less than 24 hours' notice will be charged at the regular session rate.

I authorize the therapist to charge my card for my late cancellations or therapy services, should it become necessary:

CARD NUMBER: _____/_____/_____/_____

EXPIRES: _____/_____ CV (3 numbers on back of card): _____ Billing zip: _____

NAME AS IT APPEARS ON CARD: _____

SIGNATURE: _____

Payment for services is due at the time of service and is the responsibility of the client. Due to a wide variety of insurance policies, I cannot guarantee that, if you choose to file for reimbursement, your insurance company will reimburse you. You are ultimately responsible for payment. If you fall behind on payment, I have the right to discontinue services until payment for prior services is received. I agree to have an updated valid credit or debit card on file through active care.

Initial here: _____

RETURNED CHECKS will be charged a $25 fee.

I have read this page, received a copy, and agree to abide by the policies and procedures described.

DATE: _____/_____/_____

Client Signature: _____

Signature of Responsible Party (Financial Guarantor) if different:

_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice and ability to read the HIPAA Notice on the clipboard in the waiting room or on the website; copies are available upon request.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature: _____

Date: _____