INTAKE FORM

# Melissa Friesenhahn, MA, LPC

**~ Licensed Professional Counselor~**

 Date:

**Black Ink Only**

This form will help your counselor understand more about you and will be part of your case file.

Last Name: First Name: MI:

Birth Date: Age: Gender: Male Female Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

City State Zip Code

Client SSN# DL#

**Please provide the number that is the best to reach you:**

|  |  |  |
| --- | --- | --- |
| Home Phone:  | Work Phone:  | Cell Phone: |
| May we leave a message or text? Yes No  | May we leave a message or text?  Yes No  | May we leave a message or text?  Yes No  |

Occupation: Employer:

Marital Status: Prior Marriages: \_\_\_\_\_\_\_\_\_\_\_Education:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Last Name: Spouse First Name: Spouse MI:

Occupation: Employer:

Children:

Name Sex Age Relationship to you

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Primary Care Provider: Phone Number: Fax:

Psychiatrist: Phone Number: Fax:

**I would like for the Therapist to communicate with my Primary Care Provider regarding my Treatment: Yes or No**

**I would like for the Therapist to communicate with my Psychiatrist regarding my Treatment: Yes or No**

**INSURANCE INFORMATION**

Insurance Company: Policy Number:

Insurance Telephone Number: Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name/Insured Name:

Insured SSN: Insured Birth date:

Who referred you: Self Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Web Insurance Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Concern:**

|  |
| --- |
| What brought you here today? |

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| --- | --- | --- | --- | --- |
| **Please use the following scale to answer the next three questions:** | 1 | 2 | 3 | 4 |
|  |  | Not at all | Mildly | Moderately | Highly |
| 1. | How serious do you consider your present concern(s)? |

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| 2. | How motivated are you to resolve your concern(s)? |

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| 3. | How optimistic are you that your concern(s) can be resolved? |

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Previous Counseling? Yes / No Counselor: Date:

**Please list your current medications and doses:**

|  |  |
| --- | --- |
| Prescription: | Supplements: |

Please list any Food or Drug Allergies or any adverse reactions you have experienced:

|  |
| --- |
|  |

**Please list any medical problems:**

Medical Conditions Date of Diagnosis

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| --- | --- |
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Prior Hospitalizations:

Suicide Attempts or Self Injury Behaviors:

Age Related Issues (health, employment, disability):

**FAMILY MEDICAL AND MENTAL HEALTH HISTORY**

**Please check any medical and /or mental health conditions that apply to any family members:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Heart Disease/Condition |  | Head Injury or Headaches  |  |  |
|  | High Blood Pressure |  | Seizures |  | Depression |
|  | Heart Attack |  | Thyroid Disease |  | Anxiety or Panic Attacks  |
|  | Stroke  |  | Asthma |  | Bipolar Disorder |
|  | Use or Abuse Alcohol or Drugs  |  | Diabetes |  | Eating Disorders |
|  | Cancer |  | Other Medical Conditions: |  | Other Mental Health Conditions: |
|  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Family History****Continued** | Mother’s Age \_\_\_\_\_\_\_\_\_\_\_\_\_ If deceased, how old were you when she died? \_\_\_\_\_\_\_\_\_\_  |
| Father’s Age \_\_\_\_\_\_\_\_\_\_\_\_\_ If deceased, how old were you when he died? \_\_\_\_\_\_\_\_\_\_ |
| If your parents are separated, how old were you then? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Number of brother(s) \_\_\_\_\_\_\_\_ What are their ages? \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ |
| Number of sister(s) \_\_\_\_\_\_\_\_ What are their ages? \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ |
| If you were adopted or raised with parents other than your natural parents please explain: |
| Briefly describe your mother’s personality:Briefly describe your father’s personality: | Briefly describe your stepparent(s) personality: |
| **Briefly describe your past and current relationships with your:** |
| Mother | Father |
| Stepmother | Stepfather |
| Religious Affiliation |

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| --- |
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 | Jewish  |

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| --- |
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 | Christian/Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| --- |
|  |

 | Catholic |

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 | None, but I believe in God |
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 | Protestant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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 | Atheist or agnostic |
| Do you desire to have your religious beliefs and values incorporated into the counseling process? (Please check one)  |
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 | Yes |

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 | No |

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 | Not Sure |
| **Please mark all of the following that apply** |
|  **Feelings** | Thoughts |
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 | Helpless |

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| --- |
|  |

 | Anxious/Fearful |

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| --- |
|  |

 | Confused |

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| --- |
|  |

 | Racing |
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| --- |
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 | Depressed/Sad |

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| --- |
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 | Out of Control |

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 | Fragmented |

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 | Obsessive |
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 | Shameful |

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 | Afraid/Scared |

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 | Worthless |

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 | Distracted |
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 | Angry |

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 | Burnt out/worn out |

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 | Unmotivated |

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 | Intrusive Memories |
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 | Guilty/Remorseful |

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 | Relaxed |

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 | Unattractive |

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 | Paranoid |
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 | Hopeless/Hopeful |

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 | Happy/Excited  |

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 | Unlovable |

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 | Worry |
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 | Lonely |

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 | Irritable |

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 | Confident |

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 | Sensitive |
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 | Grieved |

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 | Empty/ Numb |

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 | Worthwhile |

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 | Distrust |
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 | Stressed |

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 | Insecure |

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 | **Suicidal or Homicidal**  |

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 | Positive |
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 | Unhappy/Unfulfilled |

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 | Mood Swings |  |
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 | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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 | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Symptoms/Behaviors |
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 | Eating More or Less |

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 | **Acting Out Sexually** |

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 | Financial Difficulties |
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 | Procrastinating |

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 | Acting Aggressively |

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 | Legal Problems |
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 | Impulsivity |

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 | Phobia/Panic Attacks |

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 | Parent/Child Conflicts |
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 | Irritability |

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 | Post Traumatic Stress Disorder |

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 | Marital Problems |
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 | Crying |

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 | Attention Deficit Disorder/ADHD |

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 | Relationship Concerns |
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 | Passivity |

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 | Chronic Pain  |

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 | Withdrawal from Family/Friends |
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 | Acting Compulsively |

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 | Prior Substance Abuse Treatment |

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 | Job Problems |
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 | Poor Self-Image |

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 | **Legal/Illegal Drug Use** |

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 | Spiritual Issues |
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 | Poor Concentration/Memory |

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 | **Alcohol Use/Abuse** |

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 | **Victim or Perpetrator of Abuse**  |
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 | Injuring Self  |

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 | **Tobacco Use** |

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 | Seeing/Hearing things others don’t |
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 | Sexual Concerns  |

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 | **Sex Addiction**  |

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 | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  **Physical Symptoms** |  |
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 | Insomnia | **Family History of Mental Health Issues:** Mothers Family History:  Fathers Family History:  |
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 | Tired/ Easily Fatigued |
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 | Restlessness/Tense |
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 | Rapid Speech |
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 | Headaches |
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 | Tightness In Chest |
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 | Dizziness or Light-headedness |
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 | Numbness or Tingling | **Cultural Considerations:** **Please share anything else that might be helpful for your counselor to know:** |
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 | Pain |
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 | Rapid Heart Beat |
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 | Weight Gain or Loss |
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 | Excessive Sleep |
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 | Loss of Memory |
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 | Eating Problems |
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 | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Who may we contact in an emegerency?­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client:

I authorize Melissa Friesenhahn to use my health information to activate my insurance benefit program. The purpose will be to process claims for insurance payment. I also understand my privacy will be respected and procedures will follow the HIPAA Privacy Notice that I have received.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature (if client is under 18) Date

**Child/Adolescent Developmental History**

***(for ages 17 and younger)***

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **What was your child’s birth weight?**\_\_\_\_\_\_\_\_ lbs. \_\_\_\_\_\_\_\_ oz. Unknown**Was delivery normal?**Yes UnknownNo; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Did the birth mother experience any physical or emotional problems during pregnancy?**Yes; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unknown**Were medications taken during pregnancy?**Yes; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unknown**Did the birth mother consume alcoholic beverages or abuse any street drugs during pregnancy?**Yes; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unknown**Did the baby experience any problems immediately after birth?**Yes; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unknown**Has your child ever required hospitalization?**Yes; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unknown**Is there any history of physical, sexual or emotional abuse?**Yes; specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unknown**Is there a history of prolonged separations or traumatic events?**Yes; specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unknown | **At what age did your child do the following?***(Italicized areas reflect normal development)****\_\_\_\_\_\_\_\_*** smiled *(6 mths)*\_\_\_\_\_\_\_\_sat alone *(6 to 10 mths)*\_\_\_\_\_\_\_\_ talked in sentences *(30 to 36 mths*)\_\_\_\_\_\_\_\_ walked by self *(12 mths)*\_\_\_\_\_\_\_\_ held head up (*3 to 4 mths)*\_\_\_\_\_\_\_\_ fed self *(2yrs)*\_\_\_\_\_\_\_\_ crawled *(6 to 10 mths)*\_\_\_\_\_\_\_\_ rode a bike *(6 yrs)*\_\_\_\_\_\_\_\_ rolled over *(6 mths)*\_\_\_\_\_\_\_\_ talked in single words *(18 to 24 mths*)\_\_\_\_\_\_\_\_ pulled up *(6 to 10 mths)*\_\_\_\_\_\_\_\_ established toilet training *(2 ½ to 4 yrs)***How would you describe your child’s approach to new situations?**Positive, jumps right inWithdrawn, tends not to participateSlow to warm up; cautious**How would you generally describe your child’s overall mood?**Positive (happy, laughing, upbeat, hopeful)Negative (depressed, cranky, angry, hostile)Mixed but more positive, than negativeMixed but more negative than positive**Which school is your child currently attending?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Is your child currently receiving special services in this school?**Yes; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No**Has your child ever failed a class or been held back for academic reasons?**Yes; specify grade: \_\_\_\_No**Is your child expected to pass this school year?**YesNo |

# **Melissa Friesenhahn MA, LPC**

 **Licensed Professional Counselor, LPC**

### OUTPATIENT SERVICES CONTRACT

# **COUNSELING SERVICES**

Welcome to my practice. This document contains important information about professional services and business policies. Please read it carefully and jot down any questions you have so they can be discussed. When you sign this document, it will represent an agreement between us.

Counseling is not easily described in general statements but depends on the counselor, client and the particular problems presented. Counseling calls for an interaction between therapist and client and for therapy to be successful, clients are to employ concepts, strategies and techniques discussed during sessions. Therapy can have some unpleasant aspects that may be coupled with uncomfortable feelings. However, these experiences often lead to improved relationships, solutions to problems, and a reduction in feelings of distress.

# **COUNSELING SESSIONS**

Issues and concerns are evaluated during the first session and continue throughout the therapeutic process. During this time, it can be determined if the client/therapist relationship will be able to generate the desired treatment goals. Counseling sessions are 45-60 minutes and begin on a weekly or bi-weekly schedule and are then scheduled less frequently based on progress. The client is responsible for scheduling their sessions and canceling them if they are unable to attend. **We request a twenty-four hours notice or a $30.00 fee will be assessed for the missed session. A $50.00 fee will be assessed for any session missed without notification.** This fee cannot be billed to your insurance and must be paid out of pocket at the next session. The office answering machine is on 24 hours a day for your convenience.

# **PROFESSIONAL FEES AND BILLING SERVICES**

The fee for the initial therapy session which includes the initial evaluation and initial treatment planning is $110.00. Subsequent individual therapy sessions are **$90.00 - $110.00 and couple/family therapy sessions are $90.00-$140.00.** Unfortunately, since most insurance companies do not consider couple’s therapy as medically necessary, each session will be billed at the private pay rate, which ranges from $90 - $140. Payment is expected from the client at the time of service or from the insurance company. **Insurance only covers what is medically necessary.** Insurance is to be activated before scheduled therapy. The billing person works with the client concerning pre-certification and explanation of benefits. Other professional services such as preparation of documents or treatment summaries will be billed at the same rate as counseling.

**PLEASE NOTE: The therapist does not participate in legal proceedings but will refer the client to another clinician or entity that deals with legal issues. Please discuss this with the therapist if the need arises.**

# **CONTACTING ME**

The office telephone is answered from 10:00 AM and 6:00 PM, Monday thru Thursday, and our voicemail is available 24 hours a day. The therapist is usually in session and not available by telephone. Please leave a message with the support staff or on the voice mail. Every effort will be made to return all calls as soon as possible. Every effort will be made to return all calls as soon as possible. In case of an urgent need or emergency on weekends or after hours, the client is encouraged to call 911 or go the nearest emergency room.

## PROFESSIONAL RECORDS

The laws and standards for counseling in Texas require the therapist to keep treatment records. These records are confidential and will not be released to anyone without the client’s consent. Please be aware that the client may choose not to release these records if they can be emotionally or legally damaging. The therapist will make these records available to another mental or medical health professional at the client’s request.

## MINORS

The therapist is committed to providing confidentiality for adolescent clients. The therapist will provide generalized (not specific) information about the therapy sessions to the parents/guardians of the client. The therapist will provide more specific information as approved by the adolescent client. Parents of children in therapy are involved in the process and participate in formulating the treatment goals.

PLEASE NOTE: The therapist will ask for help from a parent or guardian if the client is at risk of seriously harming him/her self or someone else. There are also other situations that may require the therapist to release the records of minors.

## CONFIDENTIALITY

The privacy of all communications between a client and therapist is protected by law, and the therapist can only release information about their work with the client’s written permission. However, there are exceptions:

* The therapist is legally obligated to take action to protect a child, elderly person or disabled person from abuse by reporting the action to the appropriate state agency.
* The therapist will contact family members or others if there is a threat of serious self harm or harm to another. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. In these cases, a more intensive treatment plan will be developed by the therapist, the client and their family members.
* The therapist is legally obligated to release the client’s therapy notes (or a summation) if requested by a court of law.

On occasion the therapist may need to consult with other professionals about a case. During these consultations, cases are discussed without revealing the identity of the client. The consultant is also legally bound to keep all information confidential.

Questions or concerns about confidentiality can be discussed with the therapist

**FEDERAL HEALTH INSURANCE PORTABLITIY AND ACCOUNTABILITY ACT (HIPAA)**

This law insures the confidentiality of all electronic transmission of information about the client. Whenever the therapist transmits information about the client electronically (i.e. sending bills or faxing information), it will be done with special safeguards to insure confidentiality. If the client elects to communicate with the therapist by email, please be aware that email is not completely confidential. Any email the therapist receives from the client and any responses sent, will be printed out and kept in the client’s treatment record.

Your signature indicates that you have read this document and consent to treatment. This will serve as a contract between you and the provider:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Printed Name Date

If client is under 18, parent/guardian consent is needed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Printed Name Date

**Coordination of Care between Health Care Providers / Release of Information**

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. **This form will allow your behavioral health provider to share protected health information (PHI) with your other provider or person you designate below**. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

**Patient Rights**

• You may end this authorization (permission to use or disclose information) any time by contacting the practitioner’s office.

• If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.

• You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.

• You have a right to a copy of this signed authorization.

• If you choose not to agree with this request, your benefits or services will not be affected.

**Patient Authorization**

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent** **expires twelve (12) months from the date of my signature below unless otherwise stated herein.**

\_\_Melissa Friesenhahn M.A., LPC is authorized to release protected health information related to the

(Provider Name-Please Print)

evaluation and treatment of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_\_.

(Member Name) (Date of Birth – MM/DD/YYYY)

PCP Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP Phone/Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCP Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BH Provider/Psychiatrist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BH Provider Phone/Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BH Provider Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Other Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Phone/Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of Patient, Parent, Guardian or Authorized Representative) (Date)

If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)

\_\_\_ **I hereby *refuse* to give authorization for any release of information**

**CREDIT CARD AUTHORIZATION FORM**

**Alamo Counseling is authorized to maintain credit card payment information in our confidential files. This form is provided for you to supply Alamo Counseling this information. Your signature, below, authorizes us to review this information and deduct fees from the credit card below in the case of a cancelation less than 24 hours, or in the case of a session missed without notification, co-pays due, and past due amounts.**

**We accept all major credit cards at this time.**

**A Health Savings account (HSA) or employee paid benefits account card may not be used for cancelation fees.**

|  |
| --- |
| CARD INFORMATIONCard Type: Visa MasterCard Discover Other \_\_\_\_\_\_\_\_\_Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_ CVV Code (on back): \_\_\_\_\_\_\_\_\_\_\_Billing Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_Cardholder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **If anyone other than the cardholder is authorized to use this credit card, please have him or her print and sign his or her name:**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cardholder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**I understand that my card will be charged on the day of my scheduled appointment if I cancel last minute (less than 24hrs before) or no show (missed without notification I understand my card will be charged $30.00 for a cancelation, $50.00 for a no show, co-pays due, and past due amounts.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_