

Heather Resneder, MA, LMFT-S
Licensed Marriage & Family Therapist- Supervisor
Campbell Counseling Group, PLLC

New Client Intake Form

Date: _____ Name: _____ Date of Birth: _____

Home #: _____ Messages Y or N Cell #: _____ Messages Y or N

Complete Address: _____

Email: _____ Driver's License Number: _____

Relationship Status: _____ Name of Significant Other: _____

Children (Names & Birthdates): _____

Special Considerations & Custody: _____

How were you referred? _____ Previous Counseling? Y or N Helpful? Y or N

Please circle if history of: Anxiety Major Depression Grief Substance Use Suicide Attempts Abuse

Please explain any contact with CPS, police or legal proceedings: _____

When was your last physical? _____ How is your current physical health? _____

Please list current medications and prescriptions: _____

Current substances used: _____ How often? _____

Please list any important historical medical events: _____

What are you hoping to gain from counseling? _____

Emergency Information:

Who should be contacted? _____ Relationship to you?: _____

Phone #: _____ Does this person know you are in counseling? Y or N

In an emergency limited confidentiality may be compromised

Please note charges for services are due and payable at the time of your visit.

Please circle your preferred method of payment: Cash Check HSA Card Credit Card

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Information & Consent

This document is designed to inform you about the counseling experience and to ensure that you understand our professional relationship. I am licensed in the State of Texas to practice Psychotherapy and Marriage & Family Therapy. I am also a Supervisor for interns in the field. I am a member of the American Association of Marriage and Family Therapists. Counseling services may include individuals, couples, or families and from time to time other significant guests. On occasion group sessions or informative workshops may be offered.

Nature of Counseling Although our sessions may be very intimate psychologically, it is important for you to realize that we have a counseling relationship rather than a social one. You will be served best if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. Every situation is unique, while some require only a few sessions, others may take longer to resolve. As a client, you may end our counseling relationship at any point. I will be supportive of your decision. If counseling is successful, you should feel that you are able to face life's challenges in the future without my support or intervention.

Sometimes through the course of therapy uncomfortable feelings (anxiety, sadness, anger or guilt) may surface. It is a normal part of the therapy process and discussing these can further growth. Please do not hesitate to bring this up during your sessions. While, it is impossible to guarantee specific results regarding counseling and therapeutic goals, I hope to provide comfort, insight and support through these challenging times. Together we can find the best suitable results for you.

I maintain a strict no secrets policy while treating couples and families. Simply meaning that in order for therapy to be productive secrets will not be kept from others in the treatment group. I can help you articulate your needs in a safe environment but cannot hide information from other family members participating in treatment.

I assure you all services will be in a professional manner with regard to legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may make a formal complaint to the Texas Board of Marriage and Family Therapists, in Austin, Texas. Their phone number is 1-800-942-5540. Please also be aware that I will gladly provide referrals, if necessary.

Confidentiality

All sessions are strictly confidential to the persons involved in that session. I will not disclose information to others in any manner unless: (A) you give me consent to share information with someone else; you may request I release or limit information given to others. (B) I have reason to believe you are a danger to yourself or others; (C) I am ordered by court to disclose information; (D) you report the occurrence of child, disabled person or elder abuse. If our lives cross paths in a public setting I will not initiate contact, protecting your confidentiality. It is your choice to engage my attention but please remember therapy should only occur in session.

Social Media

Therapy is a process that is very personal. To protect your confidentiality we will not be connected through social media. You are welcome to share your own social media interactions

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with me during session. Please understand any social media I personally use is not intended for clients.

Fees

Initial consultations, up to 20 minutes, by phone or in person are free of charge, this gives each of us the opportunity to see if we can work together to achieve your goals. The base fee is \$100 for each 50 minute session. Children and young teens will be seen for 30-40 minutes individually to allow for follow up with a guardian immediately following. If required, longer sessions of 90 minutes may be scheduled but must be done in advance. Fees for these sessions are \$150 dollars. Financial accommodations for unique circumstances may be available, please discuss these in the initial session.

Payments may be made in cash, check or credit card at the time of the session. Returned checks will be charged \$30 and future payments will need to be in cash or credit card.

Insurance

At this time, insurance is not accepted. However, I can provide a receipt with diagnostic coding for submission to your insurance company. Each agency has guidelines for reimbursements; please contact your company specifically if you will be using insurance.

Missed Sessions

In the event that you are not able to keep your appointment, please notify me 24 hours in advance. This courtesy allows for other clients to be seen. You will be billed for your session if you do not notify me prior to your appointment. If you are more than 15 minutes late, your session will be cancelled and the full rate will be charged. I am available if needed for crisis by phone and email however a convenience fee of \$25 will be due at your next appointment. For any life altering emergency, always call 911.

Documentation

Due to the nature of my business I am not available for court appearances however if this becomes mandatory by subpoena the rate is \$200 an hour which begins when I leave the office and concludes upon my return. I will not make disability determinations of any kind. Citations for school reports, courts or other like entities require time and preparation, the fees for all such documentation is \$35 for each occurrence and 25 cents per page if copies of your file are required.

Records

All sessions are documented as required by law. This clinical record is property of Heather Resneder, LMFT-S and will be destroyed 7 years after the final contact. If we have not had contact for 45 days, your case is considered closed. A closed case may be reopened at any time but may require updated information and consent.

The final page of this document is signed and kept in your client file.

Your fee for each 50 minute session will be ____ \$_____

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Acknowledgement of Informed Consent and Fees

If you have questions, feel free to ask. Please sign and date this form. Your signature indicates that you understand the policies and agree to these terms.

Signature of Client	Printed Name	Date
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Signature of parent or guardian if client is a minor	Date
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Your fee per session is ___\$_____

Office Use Only:
Written Consent not possible due to: _____

Billing Notes: _____

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Consent to Treat a Minor

I, _____state that am the biological
parent or legal guardian
of the client_____. I am authorize to
make the request and give consent for this child to participate in counseling. If there are court
orders regarding custody I hereby state that I may make this decision independently and give
consent to treatment.

Parent Signature

Contact necessary with additional Guardians:

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION IS USED AND HOW YOU CAN GET ACCESS. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 1, 2012, and will remain in effect until we replace it. .

We reserve the right to change our privacy practices and the terms of its Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change its Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose health information about you for treatment, payment, and healthcare operations. For example: **Treatment:** We may use or disclose your health information to a physician or other health care provider providing treatment to you. **Payment:** We may use and disclose your health information to obtain payment for services we provide to you. **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing, activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others,

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient, under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS: You have the right to look at or get copies of your health information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint.

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Contact: Heather Resneder, MA LMFT-S 2011 North Collins Blvd Suite 801 Richardson, Texas 75080

Telephone: 972-907-1107 Email: hresneder@gmail.com

Acknowledgement of Receipt of notice of Privacy Practices

You My Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Please Print Name)

(Signature)

(Date)

For Office Use only*****

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refuse to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please Specify)

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Authorization for Release of Confidential Information

I, _____ Date of Birth: _____
(Client's Name and or/Legal Guardian)

hereby authorize Heather Resneder, M.A. LMFT, to release information to and receive information from:

(Person/Organization) (Telephone number)

(Address)

I understand that I am giving permission for my therapist, Heather Resneder, M.A. LMFT-S to disclose confidential information in regards to my treatment.

The information to be disclosed includes

- All mental health records Other _____
- Progress in Treatment
- Diagnosis
- Treatment Plan

I understand that I may revoke, in writing, this authorization at any time, except to the extent that action has already been taken in reliance on it. I understand that this information may be redisclosed by the recipient named above and at that time would no longer be protected by Heather Resneder, MA LMFT-S. I agree that a photocopy or facsimile of this authorization is as valid as an original. This authorization for release of information will expire one year after the date it was signed.

Date: _____

Printed name of Client

Signature of Client

Printed name of Witness

Signature of Witness

Printed name of Parent/Guardian

Signature of Parent/Guardian