LAUREN SMITH COUNSELING

2929 North Central Expressway Suite 100 Richardson, TX 75080

www.campbellcounselinggroup.com

NEW CLIENT INTAKE FORM

Name of Client: _____

Drivers License No.: _____ State: _____ Age: _____ Sex: ____

Date of Birth: _____ Race: _____ Religion: _____

Street Address: _____ Email: _____

City: _____State: _____Zip: _____ Cell Phone: _____

Employer/School:_____ Work Phone: _____

Job Title: _____ Education (Degree or Yrs Completed) _____

Marital Status (Circle One): Single / Engaged / Married / Separated / Divorced / Widowed / Cohabitating

Spouse/Parent/Guardian Information (if applicable)

Name of Spouse/Guardian: _____ No. of Years Married:_____

Date of Birth: _____ Age: _____ Sex: _____ Religion: _____

Street Address: _____ Contact Phone #: _____

City: _____ State: _____ Zip: _____

Employer: _____ Education (Degree or Yrs Completed) _____

Job Title: _____

Children (if applicable):

Name:	**Sex:**	**Age:**	**Comments:**	**Living at home?**

Who referred you to Lauren Smith Counseling? _____

Primary reason(s) for seeking services (circle all that apply):

Anger Management Anxiety Coping Behavior Concerns

Depression Eating Disorder Fear/Phobias Mental Confusion Sexual Concerns

Alcohol/Drugs Marital Concerns School Issues Relationship Concerns Premarital Counseling

Other (specify): _____

List your current concerns in the order of their importance:

_____

_____

Is there history of any of the following? (Circle all that apply):

Suicide Attempts ADD/ADHD Major Depression Grief Issues

Anxiety Abuse (sexual, physical, verbal) Domestic Violence

Contact with Child Protective Services or similar agencies

What do you hope to gain from counseling at this time?

_____

_____

Have you had any previous counseling? Yes No

When: From _____ to _____

Issues dealt with: _____

How it was helpful: _____

Reason for termination: _____

Development:

Are there special, unusual, or traumatic circumstances that affected your development? Yes / No

If "yes" please describe: _____

Has there been any history of child abuse? Yes / No

If "yes" which type? Sexual Physical Verbal

If "yes" the abuse was as a: Victim Perpetrator

Other childhood issues: Neglect Inadequate Nutrition

Other: _____

Comments regarding childhood development: _____

_____

Social/Cultural:

Circle how you generally get along with other people:

Affectionate Aggressive Avoidant Fight/Argue often Follower

Friendly Leader Outgoing Shy/Withdrawn Submissive

Other: _____

Are you experiencing any problems due to cultural or ethnic issues? Yes No

If "yes", describe: _____

Legal:

Are you involved in any active cases (traffic, civil, criminal)? Yes No

If "yes", please describe and indicate the court and hearing/trial dates and charges: _____

_____

Are you currently on probation or parole? Yes No

If "yes" please describe: _____

If you responded YES to any of the above, please fill in the following information:

Charges Date Where(city) Results

_____

_____

_____

Medical/Physical:

Physician's Name: _____

Address: _____ City: _____ State: ___ Zip: _____

Is it okay for your counselor to contact your physician for case management? ____ yes ____no

Please circle any that apply:

aggressions	alcohol dependence	anger	antisocial behavior	anxiety
avoiding people	bullying	chest pain	cutting	disorientation
distracted	dizziness	drug use	eating issues	elevated mood
fatigue	hallucinations	high blood pressure	hopelessness	impulsiveness
irritability	judgment errors	loneliness	memory impairment	mood shifts
panic attacks	phobias/fears	recurring thoughts	sadness	sexual problems
sleeping issues	speech problems	suicidal thoughts	withdrawing	worrying

List additional illness, physical conditions or complaints you want the counselor to know:

_____

_____

Current Prescribed Medication: Dose: Purpose: Side Effects:

_____

_____

_____

Current Over the Counter Medication: Dose: Purpose SIde Effects:

_____

_____

Date of last physical exam: _____

Family history of medical problems: _____

Circle if there have been any changes in the following:

Sleep Patterns Eating patterns Behavior Weight Anxiety

Energy Level Physical Activity General Disposition Other: _____

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Counseling Fee Agreement Form

Lauren Smith Counseling fee for a **50-minute** individual, family or marital counseling session is **$110**.

PAYMENT: Payment for the counseling session is **due at the time of the appointment,** unless prior arrangements have been made. Cash, credit cards or personal checks made out to Lauren Smith Counseling are acceptable for payment. **A returned check fee of $25.00 will be charged on any returned check.** If you have an outstanding balance you may be mailed a statement requesting payment from Lauren Smith Counseling. Any outstanding *balances not paid within 60 days* may be turned over to a collection agency. Lauren Smith Counseling will protect its right under the law to recover any and all monies owed by you. All legal proceedings will be filed in Dallas County, Texas. Limited personal information about you will be given out in order to collect outstanding balances.

INSURANCE BENEFITS: Some insurance companies will pay part of counseling fees, others will not. If you would like to use insurance benefits for your session, Lauren Smith Counseling may be able to file for you. A copay may be required and can be paid by cash, check or credit card. *Please check your health benefits with your insurance prior to beginning counseling or have Lauren Smith Counseling check your benefits prior to first session.*

CANCELLATION POLICY: Clients will be charged **$30.00** for canceled appointments unless the counselor is notified **24 hours prior to the appointment time.** Exceptions may be made for emergencies. If you are late for an appointment, the session will still end at the scheduled time, and you will be charged for a full session. **Balances for failure to show or a cancelled appointment must be paid before another session can be held.**

AGREEMENT: My counselor has reviewed the above policies with me and I understand these policies.

_____ _____

Client Date

LAUREN SMITH COUNSELING

Counseling Agreement Form

Counseling Relationship: The counseling relationship is a professional relationship, not a social one. Sessions may be weekly or at a intervals necessary to meet the collaborative treatment goals we have agreed upon. Contact will be limited to counseling sessions that you arrange at a predetermined time convenient for both of us. In case of an emergency, call 911.

Records and Confidentiality: All of our communication becomes part of a clinical record which is the property of Lauren Smith Counseling. Adult files are disposed of seven years after the case is closed. Cases of minors will be disposed of 5 years after they turn 18 years old. Communication between us is confidential except in the following instances:

- I determine that you are a danger to yourself or others
- You disclose abuse, neglect or exploitation of a child, elderly or disabled person
- I am court ordered to disclose information regarding your case
- You disclose sexual contact with another mental health professional
- You direct me in writing to release your records
- I am otherwise required by law to disclose such information

If I see you in public I will protect your confidentiality by acknowledging you only if you approach me first.

Documentation: Due to the nature of the counseling profession, I am not available for court appearances. However, if this becomes mandatory by subpoena, you will be charged a fee of $200 per hour which begins when I leave my office/home 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 fee for all such documentation is $35 for each occurrence and $0.25 per page if copies of your file are required.

Outcome of Counseling: At any time you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing or not continuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these changes can be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Clients Rights: Some clients only need a few sessions of counseling; others need several weeks or months. You may end our counseling relationship at any time, although I do ask that you do so in a final session with me. Counseling is a cooperative process between a client and therapist; please discuss any concerns you have openly with me so they can be addressed. I assure you that my services will be rendered in a professional manner with accepted legal and ethical standards. If at any time you are dissatisfied with my services, please let me know. If I am unable to resolve your concerns, please contact the LPC licensing board @ 512-834-6658, or via email at lpc@tdh.state.tx.us

LAUREN SMITH COUNSELING

ACKNOWLEDGEMENT OF INFORMED CONSENT FOR COUNSELING

I hereby request that I, (**client** name) _____, be accepted for psychotherapy and mental health counseling as described to me. (See below for consent for a minor)

1. I have given my authorization and freely consent to receive outpatient diagnostic and counseling services from Lauren D. Smith MA LPC -S.

2. I have received information regarding the licensure and experience of my therapist.

3. I have been given the “Counseling Agreement Form” which includes information regarding my rights and responsibilities as a client, information regarding the limits of confidentiality of my records and which outlines the cost of services from Lauren D. Smith MA LPC-S. I understand that I am financially responsible for payment in full for all services rendered through Lauren D. Smith MA LPC-S.

4. I agree to adhere to Lauren D. Smith’s cancellation policy. I understand that my appointment time is reserved exclusively for me. The fee for a No Show or Late Cancellation (cancel with less than 24 hours notice) is **$30.00**. A no show or late cancel fee is not covered by insurance companies therefore, I will be responsible for the full fee.

5. I have been given the opportunity to ask and have answered any questions regarding my counseling agreement with Lauren D. Smith MA LPC-S and understand as future questions may arise I may address them with Lauren D. Smith MA LPC-S. I understand that the therapist may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of my treatment and that I have the right to consent to or refuse such treatment.

6. I further understand that I may stop my treatment at any time, but agree to discuss this decision first with the therapist. My only financial obligation, should I decide to stop treatment, is to pay for the services I have already received.

7. Counseling for a minor child, if applicable:
   I, _____, do hereby state that I am the biological parent and/or legal guardian of the client: therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form. If there is a divorce decree, modification to a divorce decree or other court order affecting the parent-child relationship applicable to this child, I do hereby state that according to the current court order I have the **independent** right to make this request for and give my consent to the treatment and services mentioned in this form.

_____ _____

Signature of Client or Legal Guardian Date

LAUREN SMITH COUNSELING

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

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 January 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 health care operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health care Operations: We may use and disclose your health information in connection with our healthcare operations. Health care 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 health care, 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 health care. 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.

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 authorized 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 ,

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. 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. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.35 for each page, $12.00 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer,

we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

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, health care operations, and certain other activities, but not before March 1, 2012. 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 with us or the U.S. Department of Health and Human Services.

Contact: Lauren D. Smith
2929 North Central Expressway Suite 100
Richardson, TX 75080

Phone: 972-907-1107
Email: laurensmith.ccg@gmail.com
Website: www.campbellcounselinggroup.com

LAUREN SMITH COUNSELING

Acknowledgement of Receipt of Notice of Privacy Practices

****You May 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 acknowledgement 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)

_____