Kristina Stephens Counseling

Campbell Counseling Group, PLLC

New Client Intake Form

Client Information:

Name of Client: ____

Driver's License No.: ____________________ State: ____ Age: ____ Sex: ____

Date of Birth: ________________ Race: ________________ Religion: ________________

Street Address: ________________________________ Home Phone: ________________

City: ________________ State: ____ Zip: ___________ Cell Phone: ________________

Employer: ____________________________________ Work Phone: ________________

Job Title: _____________________________ Education (years completed): ____________

Marital Status: Single / Married / Separated / Divorced / Widowed / Cohabitating

Spouse / Guardian Information (if applicable):

Name of Spouse/Guardian: ____________________________ No. of years married: ____

Driver's License No.: ____________________ State: ____ Age: ____ Sex: ____

Date of Birth: ________________ Race: ________________ Religion: ________________

Street Address: ________________________________ Home Phone: ________________

City: ________________ State: ____ Zip: ___________ Cell Phone: ________________

Employer: ____________________________________ Work Phone: ________________

Job Title: _____________________________ Education (years completed): ____________

Children (if applicable):

Name:	Sex:	Age:	Comments:	Living at Home?

Who referred you to Kristina Stephens Counseling? ______________________________

Campbell Counseling Group, PLLC

New Client Intake Form

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	Sleeping problems	Addictive Behaviors	
Alcohol/Drugs	Marital Concerns	Adoption Issues	

Other (specify): ____

____

Describe your current concerns in the order of their importance: ______________________

____

____

____

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

Suicide Attempts	ADD/ADHD	Major Depression
Grief Issues	Anxiety	Abuse (sexual, physical, verbal)

Drug/Alcohol Abuse (self or family)

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

If "yes," when: from __________________ to __________________

Name of Previous Therapist/Agency: ______________________________

Issues Dealt With: ____

Reason for Termination: ______________________________________

Campbell Counseling Group, PLLC

New Client Intake Form

Development:

Are there special, unusual, or traumatic circumstances that affected your development?

Yes / No If "yes," describe: ____

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

If "yes," which type(s)? Sexual Physical Verbal

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

Other childhood issues: Neglect Inadequate Nutrition

Other (describe): ____

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 (describe): ____

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," describe: ____

Campbell Counseling Group, PLLC

New Client Intake Form

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: ________

Please circle any that apply:

Abdominal Pain	Abortion	AIDS	Alcoholism
Allergies	Anemia	Arthritis	Asthma
Bed Wetting	Cancer	Chest Pain	Chronic Pain
Colds/Coughs	Constipation	Diabetes	Diarrhea
Dizziness	Drug Abuse	Eating Problems	Epilepsy
Fainting	Fatigue	Headaches	Hepatitis
High Blood Pressure	Measles	Menstrual Pain	Miscarriages
Mononucleosis	Mumps	Nausea	Neurological Disorders
Nose Bleeds	Scarlet Fever	Sexual Problems	Sleeping Disorders
Smallpox	STD	Stroke	Thyroid Problem
Tuberculosis	Vomiting	Whooping Cough	

Please list any current health problems: ______________________________

List any recent health or physical changes: ____________________________

Campbell Counseling Group, PLLC

New Client Intake Form

Current Prescribed Medication: Dose: Purpose: Side Effects:

____

____

____

Current Over the Counter Meds: Dose: Purpose: Side Effects:

____

____

____

Date of Last Physical Exam: ______________________________

Family History of Medical Problems: ______________________________

____

Please circle if there have been any changes in the following:

Sleep Patterns Eating Patterns Behavior

Energy Level Physical Activity General Disposition

Weight Nervousness/Tension

Other (describe): ______________________________

Chemical Use:

Name: Method: Amount: Frequency: Last Use:

____

____

____

Describe when and where you typically use substances: ______________________________

Reasons for Use: Addicted Builds Confidence Escape Self-Medication

Socialization Taste Other: ______________________________

Campbell Counseling Group, PLLC

Counseling Agreement Form

Your Counselor: Your counselor is Kristina Stephens, MA, LPC, RPT, a licensed professional counselor answerable to the Texas State Board of Examiners of Professional Counselors and her Professional Code of Ethics, and a play therapist registered by the Association for Play Therapy.

Counseling Relationship: The counseling relationship is a professional relationship, not a social one. Sessions may be weekly or at intervals necessary to meet the collaborative treatment goals we have agreed upon. During the first few sessions, we will be working toward developing an understanding of your needs and a plan for you and/or your family. We will direct our mutual efforts toward agreed upon goals determined on an individual basis. Since therapy involves a commitment of your time, energy and finances, you should be sure that you are comfortable working with me. If you decide at any time that we are not a good fit or that other services are needed, I will provide you with appropriate referrals. Successful therapy calls for an active effort on your part and will require you and/or your family to work on issues and tasks discussed during the session and also at home. 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.

Nature of Counseling: Every situation is unique. While some only require a few sessions, some may take longer to resolve. Sometimes through the course of therapy, uncomfortable feelings (anxiety, sadness, anger, guilt, etc.) 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. 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.

Campbell Counseling Group, PLLC

Counseling Agreement Form

Fee: The fee for a 50-minute individual, play, family, or marital counseling session with Kristina Stephens Counseling is $125.00.

Payment: Payment for the counseling session is due at the time of the appointment, unless prior arrangements have been made. Cash, personal checks made out to Kristina Stephens Counseling, and credit card 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 Kristina Stephens Counseling. Any *outstanding balances not paid within 60 days* may be turned over to a collection agency. Kristina Stephens 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. Kristina Stephens Counseling can provide you with a receipt/super-bill you can send to your insurance company for possible reimbursement. We will only accept your co-pay and file insurance with approved insurance agencies (please ask for a current list). *Please check your health benefits with your insurance prior to beginning counseling.*

NOTE: Separate Insurance Agreement Form needs to be printed and completed.

Cancellation Policy: Your appointment time is reserved specifically for each client. Clients will be charged $75.00 for cancelled appointments unless the counselor is notified 24 hours prior to the appointment time. Exceptions *may* be made for emergencies. Please do not come or bring sick children to therapy if they have had a fever or vomiting within the last 24 hours. Please also use best judgment on other illnesses, as well, and notify the counselor as soon as possible, so the session can be offered to others. 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 canceled appointment must be paid before another session can be held.

Campbell Counseling Group, PLLC
Counseling Agreement Form

I am available if needed for crisis by phone and email; however, a convenience fee of $50.00 per 30 minutes will be due at your next appointment. For any life-altering emergency, always call 911. Clinical information is not shared over email, unless deemed absolutely necessary by your therapist.

Records and Confidentiality: All of our communication becomes part of a clinical record which is the property of Kristina Stephens Counseling. Files are disposed of five years after the case is closed. If we have not had contact for 45 days, your case will be considered closed. A closed case may be reopened at any time but may require updated information and consent. 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, elder 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

The following business practices, though not all-inclusive, may constitute a potential risk to your confidentiality, in spite of the security measures that I have in place to protect your privacy. By signing below you understand and acknowledge the possible risk and your consent for such practices to be utilized.

- Use of an electronic calendar
- Use of a paper calendar
- Use of a cell phone for communication with you and other professionals
- Use of a laptop computer and/or tablet
- Use of unencrypted email
- Use of computerized billing
- Use of shared office space with the independent practices of other mental health professionals with potential access to, among other things, common storage and file space, mailboxes, voicemail, messages, fax machine and faxes

There are always serious concerns about releasing clinical notes, which are written by and for the therapist, to parents of minors. I believe it is potentially damaging to the child, the

therapeutic relationship, and can often have farther-reaching consequences to the client. I prefer to release a clinical summary, if that is agreeable. That being said, I will of course follow the obligations outlined in the Texas Health and Safety Code regarding the release of records.

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

Court/Deposition Fees: Due to the nature of the counseling profession, I am not available for court appearances. However, if this becomes mandatory by subpoena (by your attorney, your spouse's attorney, or your ex-spouse's attorney), you will be charged a fee of $200.00 per hour with a 4-hour minimum charge. Payment is due and non-refundable 48 business hours in advance. Any additional time spent on the day of the court/deposition appearance will be billed within 24 hours and is expected to be paid in full within 48 hours of the bill being sent. Out-of-pocket expenses associated with travel shall also be billed to you with the same expectations of payment.

You are responsible for any legal fees that I incur as related to your case or treatment. I reserve the right to suspend services if there is an unpaid balance in your account. My attorney will be in attendance for any depositions and possibly court hearing, if they are contentious enough that I believe it to be necessary. Again, you are responsible for any and all legal fees incurred as related to your case.

In cases of active litigation or post-divorce anything released from my office in writing, goes to both parties/attorneys. Every effort will be made to include both parties in the counseling process.

There is no recording of any kind permitted in the office of Kristina Stephens Counseling.

Documentation: 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 $125.00 for each occurrence and $0.25 per page if copies of your file are required.

Campbell Counseling Group, PLLC

Counseling Agreement Form

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.

Client's 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 at 512-834-6658, or contact via email at lpc@tdh.state.tx.us.

Campbell Counseling Group, PLLC

Counseling Agreement Form

Agreement: My counselor has reviewed the above policies with me and I understand these polices. I agree to pay $____________________ per counseling session, plus any additional fees as described above.

____

Client/Guardian (Please Print Name)

____

(Signature)

____

(Date)

____

Kristina Stephens, MA, LPC, RPT (Signature)

____

(Date)

Campbell Counseling Group, PLLC

ACKNOWLEDGMENT OF INFORMED CONSENT FOR COUNSELING

I hereby request that I, (print client name) ______________________________, be accepted for psychotherapy and mental health counseling as described to me.

1. I have given my authorization and freely consent to receive outpatient diagnostic and counseling services from Kristina Stephens Counseling, Kristina Stephens, MA, LPC, RPT.
2. I have received information regarding the licensure and experience of my therapist.
3. I have received the "Counseling Agreement Form" which includes information regarding my rights and responsibilities as a client, and information regarding the limits of confidentiality of my records and which outlines the cost of services from Kristina Stephens, MA, LPC, RPT.
4. I understand that I am financially responsible for payment in full for all services rendered through Kristina Stephens, MA, LPC, RPT. I agree to adhere to Kristina Stephens Counseling's cancelation policy. I understand that my appointment time is reserved exclusively for me. The fee for a No Show or Late Cancelation (cancel with less than 24 hours notice) is $75.00. A no show or late cancelation 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 Kristina Stephens, MA, LPC, RPT and understand as future questions may arise I may address them with Kristina Stephens, MA, LPC, RPT. 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 my therapist. My only financial obligation, should I decide to stop treatment, is to pay for the services I have already received.
7. I understand that any and all information provided to me or any office staff is part of the clinical file.

Campbell Counseling Group, PLLC

ACKNOWLEDGMENT OF INFORMED CONSENT FOR COUNSELING

8. I understand that there is no recording of any kind permitted in the office.
9. I understand that communication with my counselor via electronic devices (as discussed above) can create limits to confidentiality.
10. Counseling for a minor child, if applicable:
    a. 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 of 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.
    b. I understand that in the cases of divorce, separation, or currently involved in any legal proceedings, that Kristina Stephens Counseling will reach out to all legal guardians to invite them to be a part of the therapy process.
    c. I understand that in accordance to Texas Family Code 104.008, your therapist cannot provide comment on the evaluated possession and access of a child.
    d. I understand that in cases involving custody, counseling cannot begin until I provide a FILE STAMPED copy of the most recent legal proceedings.

____________________________________ ____________________

Signature of Client/Guardian Date

____________________________________ ____________________

Signature of Kristina Stephens, MA, LPC, RPT Date

Campbell Counseling Group, PLLC

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, 2010, 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.

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.

Campbell Counseling Group, PLLC
NOTICE OF PRIVACY PRACTICES

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 $0.25 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, 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 charger 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).

Campbell Counseling Group, PLLC
NOTICE OF PRIVACY PRACTICES

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 or 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: Kristina Stephens, MA, LPC, RPT
2011 N. Collins Blvd., Ste. 801
Richardson, TX 75080

Telephone: 972-907-1107
Email: kristinastephenscounseling@gmail.com
Website: www.campbellcounselinggroup.com

Campbell Counseling Group, PLLC

Acknowledgment of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

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 refused to sign

( ) Communications barriers prohibited obtaining the acknowledgment

( ) An emergency situation prevented us from obtaining acknowledgment

( ) Other (please specify): ____

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