CONFIDENTIAL CLIENT APPLICATION FOR SERVICES
COUNSELOR-CLIENT INFORMED CONSENT
109 Enterprise Parkway Suite 201 Boerne TX 78006, 830.981.5330

***Thank You* for Printing Clearly**
6/20/2024

Today's Date _____ 1st session scheduled _____

Client's Last Name _____First _____MI____ SSN_____

Mailing Address _____
(Street) (City) (Zip)

Email (for appointments/administration, not counseling) _____

Home #: ( ) _____-_____ Cell #: ( ) _____-_____ Work #: ( ) _____-_____
You prefer to be called/leave messages Home ( ) Cell ( ) **Preferred reminder (circle one) voice or text**

Birth Date _____ Gender ____ How were you referred here? _____

If client is a student, school attending: _____

Responsible Party (insurance/payment/for client, must be present to sign)

Subscriber/Name (printed): _____ Phone: _____

DOB: _____ Relationship to Client: _____

Mailing Address_____
(Street) (City) (Zip)
Employer: _____ Insurance ID #: _____ Group: _____

Insurance Company Name: _____ Phone #: _____

ALL FEES ARE DUE AT THE TIME OF THE APPOINTMENT. Fees are due for any scheduled appointment **unless the appointment is cancelled more than 24 hours in advance**. If the provider is not a network provider for my insurance company, I understand that it is necessary to first pay the fees and then file with the insurance company for reimbursement. Initialing and signing below shows **I agree and all overpayments can be applied to future sessions**. I authorize the release of any medical information requested by my insurance company that is necessary to process this claim or for audit purposes. I authorize payment be made to this provider for services rendered.

By signing this form, I am requesting treatment, give permission for exchanging information between my insurance company if applicable, Susan Loveland (and associates), and credit/debit companies. I agree to keep a valid credit card on file and pay charges. I accept <u>avoidably</u> missed sessions will be billed on my credit/debit card. I certify I have read and understand the HIPAA materials provided. I accept and agree to all of the policies included.

Purpose: Acknowledge consent to use and disclose health information and clarify the professional counseling relationship and expectations.

Background: Master of Arts degree (**Not a Doctor**) in counseling from St Mary's University (2006) serves as a Licensed Professional Counselor (LPC) with specialized training in art and expressive therapies, and is a Certified Eye Movement Desensitization and Reprocessing (EMDR) Therapy Therapist.

Limitations: LPC practice is limited to individuals and couples of clients who I believe have the capacity to resolve their own problems with my assistance. I believe people find happiness and contentment in their lives as they choose to gain awareness and self-acceptance, forgive and manage their boundaries. Clients understand that counseling is based on attending regularly scheduled counseling appointments and talking openly with their counselor. Clients realize they may encounter troubling emotions in the course of counseling. Although counseling is usually a beneficial process, clients understand that there can be no guarantees concerning the outcome of treatment or the achievement of specific goals. However, they can expect to be heard and accepted as a human being of value and worth. Signing below constitutes consent to the counselor to provide appropriate treatment in an ethical and professional manner and that all questions have been answered and responses accepted.

Professional Relationship Rather Than a Personal One. **Contact will be limited to paid sessions or phone calls to schedule sessions.** Please do not invite me to social gatherings, offer gifts, or ask me to relate to you in any other way than in the professional context of our counseling sessions. You will be best served if our relationship remains strictly professional and our sessions concentrate exclusively on your concerns**. All information that is shared in therapy is held in confidence with legal exceptions listed below and identifiable information will not knowingly be shared with another medical person without your written consent. There is a vulnerable aspect in all faxes, electronic communication devices that MAY NOT BE PREVENTABLE, regardless of safeguards and reasonable measures. Therefore, technical equipment (phones) that may be deemed to cause interruptions are expected to be left out of session.**

Goals: Increase self-awareness, self-acceptance, and problem-solving skills.

Reason for Counseling: _____

Are there suicide concerns? Yes ( ) No ( ) Homicidal concerns? Yes ( ) No ( ) Drug Usage? Yes ( ) No ( )

Goals for Counseling:

_____

_____

On a scale of 1 to 5, 1 being least and 5 being most, how willing are you/the client to make changes to improve the situation (circle a #)? 1 2 3 4 5

How would you describe yourself? _____

1. Records and Confidentiality: The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your/client's privacy. Implementation of HIPAA began officially on April 14, 2003. This form is an agreement between you/the client, and this office. When we use the word "you" it refers to you as a client. When we examine, treat or refer you, we will be collecting what the laws call Protected Health Information (PHI) about you. We need to use this information here to decide what treatment is best for you and to provide treatment to you or file with insurance. We may also share your information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

2. Communication: All of our communication becomes part of the clinical record, which is accessible to you upon written request. The complete privacy notice is posted in the waiting room and/or available online or at the reception desk. Occasionally the therapist may find it helpful to consult with other health professionals about your case or for scheduling, billing, and quality assurance who have been trained and agree to protect your personal health information (PHI). The counseling practice is advanced through publication and presentations. Data obtained through our professional relationship may be subject to use in these venues. It is understood and agreed that any data released will be disguised. Note: Reasonable and minimum standards

are applied to protecting electronic and telephonic communication of your privacy information. No communication is 100% protected; signing below acknowledges accepting risk related to supporting the client's care**.** Telephones or JITUZU are preferred to arrange or modify appointments and email for payment receipts only. However, if you choose to communicate by email, be aware that you accept all risk and liability, and all emails are retained in the logs of your and Susan Loveland's Internet service providers. Confidentiality can therefore not be guaranteed. **Cell phones, watches, laptops, and other recording devices** are expected to be **left outside of session to minimize distractions.** Signatures of approval by all parties involved are required prior to any recordings; **lack of signatures invalidates recordings**.

3. Confidentiality only exists in civil cases, not in criminal cases. **I am a mandatory reporter**, and will keep confidential anything you say to me, with the following exceptions:

a. According to state and local laws, therapists must report to the appropriate agencies all cases of physical or sexual abuse or neglect of minors (Under 18) or the elderly or disabled (65 or older).

b. According to state and local laws, therapists may report to the appropriate agencies all cases in which there exists a danger to self or others.

c. When authorized by the recipient of services, in order to process medical insurance claims and authorized payment of benefits.

d. In the event that a patient is in need of emergency services and other medical personnel need to be contacted.

e. If you are a practicing provider and violating board rules, the board may be contacted.

f. If you become involved in specific kinds of legal proceedings, the **courts may subpoena information concerning your treatment, and the licensing board may request a copy, signing below acknowledges this understanding.**

4. In the event of the therapist' death or incapacity, your records are stored and accessible by Acorn Counseling PLLC, or Jessica Calderon MA, LPC or Michon Tucker MA, LPC-S at 830.981.5330 or the above mailing address. If, due to changing laws, we are required to change our Application for Service, you may get a copy from us by requesting one in writing from Acorn Counseling PLLC or www.acorncounsel.com. You have the right to ask not to use or share your information by requesting this in writing. We are not required to agree to these limits, but will take reasonable steps to honor your wishes. You also have the right to revoke your agreement, also in writing.

5. Parents/guardians/family members are expected to remain quietly in the waiting room or in their car if not included in the session(s). Please do not bring children you may have to leave unattended. There are no babysitting resources and limited waiting room facilities. Initializing acknowledges Acorn and Associates will not be held responsible for supervising dependents/friends/relatives waiting for clients.

6. Physical contact may occur in the course of play or therapy in the form of support or to protect from harm or protect boundaries. Reasonable and necessary precautions will be taken to provide positive growth, protect clients and therapists, and all situations cannot be anticipated**. It is the client/guardian's responsibility to address any concerns immediately about this subject and prior to the next session.**

7. Who May We Contact in Case of Emergency?

.

Name _____ Name _____

Address _____ Address _____

City/State/Zip_____ City/State/Zip _____

Tel. Number_____ Tel. Number_____

Primary Care Physician (name/office practice name/phone number)

_____

8. Spirituality: This practice offers Christian Counseling to include discussions about your God, optional prayer and scripture. Please indicate your desire for this kind of counseling:
Do religious/spiritual issues play a role in your concerns/solutions? Please describe your spiritual background:

9. Conflict: The therapist will play no active role in divorce/custody proceedings between _____ & _____, or share specific information that either party who confides during individual therapy sessions. The therapist's role will be to facilitate communication between members for reconciliation, and not serve as a witness for either party. Initials and signature below indicate understanding and agreement by these conditions. It is unethical for me to do any forensic evaluation during the course of treatment. **Records for couples sessions will be released to both parties.**

10. Fees and Insurance Reimbursement. Please see and initial the fee schedule.

Unless paying Private Pay, your insurance is a contract between you, your employer/source, and insurance company. Policies vary widely in services. Please note that fees are subject to change and negotiated before sessions and payments are due. Clients or Guardians are responsible for full payment of fees, regardless of insurance company policies. **Clients are responsible for notifying this office when their insurance changes, and following through with their insurance account adjustments**. Consistency is an important part of the counseling process, and the appointment time that you schedule is reserved for you; it is not available to anyone else. Once an appointment has been scheduled, you will be expected to pay for it unless you provide notice of cancellation at least 24 hours in advance or were unable to attend due to circumstances beyond your control. Messages received on the answering system are acceptable for prior notice. Sometimes it may be necessary to reschedule an appointment and every effort to contact you in advance will be done so.

a. **You should receive a receipt for every payment. The signature below constitutes agreement to request a receipt if one is not received or one is desired.**
b. **Initials indicate acceptance of financial policies and that if sessions go longer than the scheduled time of 60 minutes, the client or guardian accepts the additional fee of $50/half hour, unless the request is for public assistance for which there is no charge.**
c. **Records will be provided after the fee is received.**

Fee Schedule

Basic Individual Session	$160 (Private Pay $120)
Complex Interactive Session	$30
Consulting, Talking with Attorneys	$160/hour
Copies of Records other than Disability	$25 first 20 pages then $.50/page+ shipping
Court Appearance, paid prior to	$2500+$300/hr
Document other than for Disability	$125
Good Faith Estimate Private Pay	$120/hour + $60/half
No Show, Avoidable, Short Notice	$60

Debit/Credit/FSA/HSA Card Approval

Type of Card: _____ Name on Card: _____

Payer Zip Code: _____ Card # (last 4 only) __ __ __ __ Exp Date: _____

11. Recording sessions knowingly or unknowingly violates public rights and policies and will not be tolerated. Technical devices are required to be left outside of session. Outside video surveillance is for our safety and signing below acknowledges acceptance of the policy as well as knowing that any concern about it must be brought up promptly to the provider

12. No gifts will be accepted.

13. Are you currently receiving counseling from another counselor? Yes ( ) No ( ) If you are currently receiving counseling services from a counselor, psychologist, psychiatrist, or religious leader, I may not be able to offer you services. Please discuss this with your therapist prior to sessions beginning or when this changes.

14. Concerns or Complaints. If you have a concern or complaint with the service, we encourage you to first discuss the matter with your counselor. If you feel you cannot resolve it satisfactorily, you are encouraged to submit your complaint in writing to Acorn Counseling PLLC. An individual who wishes to file a complaint against a Licensed Professional Counselor may contact: Texas Behavioral Health Executive Council, 333 Guadalupe St., Ste. 3-900, Austin, Texas 78701, Tel. (512) 305-7700, 1-800-821-3205 24-hour, toll-free complaint system.

15. Additional policies. We work with people from all walks and orientations. We acknowledge and respect all personal and cultural beliefs that reflect different orientations toward life.

16. Termination: We may choose to discontinue the counseling relationship at any point. I will be supportive of that decision and appreciate you discussing this with me. If counseling is successful, you should be able to face life's challenges in the future without my support. **I expect open communication if there is ever a problem with the counseling service provided.** Last contact or communication constitutes termination. We must terminate or refer to other therapists if counseling is no longer a benefit to you, the client, or I feel that I can no longer be helpful. The patient has the right to terminate treatment at any time, and the practitioner may terminate for one or more specified reasons, including, but not limited to, when the patient is unable to pay the fees for the services to be rendered. Such a disclosure may include the fact that one or more referrals will be made and that the termination, depending upon the circumstances, may consist of more than one session.

By signing below, I consent to treatment with the counselor signing below, acknowledge that I have read and understand this statement and the HIPAA Notice of Privacy Practices, and my questions have been answered to my satisfaction. I understand that my counselor and I will arrive at a mutually-agreeable treatment plan and an estimate of the probable duration of my counseling. Signing this document represents an agreement between therapist and client and may be revoked in writing at any time. Email receipts will be provided and statements are available upon request.

_____/_____ _____/_____
Counselor's Signature/Date Client's Signature/Date

_____/_____
Client's Printed Name/Date

_____/_____
Parent/Guardian Printed Name/Signature/Date
Legal Authority (attach supporting documentation)

CLIENT SELF-EVALUATION

Overall physical health: Excellent ( ) Good ( ) Fair ( ) Poor ( ) Declining ( )

On a scale from 1 – 5, 1 being least and 5 being most/worst ever, please circle you/client's current level of:

Physical pain? 1 2 3 4 5

Emotional pain? 1 2 3 4 5

Mental pain? 1 2 3 4 5

Spiritual pain? 1 2 3 4 5

Environmental pain? 1 2 3 4 5

Comments: _____

_____

_____

_____

_____

Define wellness or what life would be like when your concerns are resolved - what does it look like?

_____

_____

Date (MM/YY) of last physical checkup: _____Recent weight changes: _____

Medical problems (please list all important present or past illnesses, injuries, surgeries, use the back if necessary):

_____

_____

Current Medications (prescriptions and over-the-counter)

_____

_____

Prescribing Physician(s) (name/phone): _____

Have you recently suffered a loss or major change (social, family, pet, business, move, etc.)? _____
If yes, please explain _____

_____

What is the worst thing that happened to you/the client? _____

_____

_____

What helped you/the client feel better? _____

_____

What is the best thing that happened to you/the client? _____

_____

_____

Have you ever been a victim of a crime? Yes ( ) No ( )
Are you coming to counseling for issues related to the crime? Yes ( ) No ( )
If yes, have you filed with Texas Crime Victims Compensation? Yes ( ) No ( )

If client is under age 18, who is the primary care giver (name, phone):
_____

Who is living in the house(s) of the client? Please list all if client lives in multiple dwellings (ex. joint custody)

Relationship	Name	Birth Date MM/DD/YY	Age	Gender	Occupation/ Grade

What are the client's strengths?
_____

Has there ever been struggles with pornography?
_____
_____

What else should the therapist know?
_____
_____
_____
_____
_____

Willingness to own the problem & do something? Poor Good Very Good