Wetzel Counseling

Intake Form

CLIENT INFORMATION

Client's Name: ____ Date: _____________

DOB: ______ Age: _____ Race: ________ Ethnicity: __________ Gender Identity: ______

Sexual Orientation: ________

Place of Birth: _____________________________ Grade if in school: _________________

Address: ________________________________ City, State, Zip: _______________________

Phone: _______________________ (indicate cell or home)

Place of Employment: ______________________________ Work Phone: _________________

Email: ___________________________ SS#: ___________________________________

Permission to communicate via text? Yes or No Permission to communicate via email? Yes or No

Religious Preference: ____

How were you referred? ____

Responsible Party **if the client is under age 18:**

Name of legal Guardian: ___________________________ Relationship to client: ___________

(If not biological parent please provide proof of guardianship/custodianship)

Address: ________________________________ City, State, Zip: _______________________

Phone: _______________________ (indicate cell or home) Work Phone: __________________

Email: ___________________________ DOB: _________________

Persons to contact in case of an Emergency:

Emergency contact #1: _____________________ Relationship to Client: _________________

Cell Phone: ______________________________ Work Phone: _________________________

Emergency contact #2: _____________________ Relationship to Client: _________________

Cell Phone: ______________________________ Work Phone: _________________________

INSURANCE INFORMATION

Name of Insurance Company: ____

Name of the Main Policy Holder: ____

Social Security# of Main Policy Holder: ____

Insurance ID# of client seeking services: ____

Group ID# for client seeking services: ____

Date of Birth for Main Policy Holder: ____

HISTORY OF PRESENTING PROBLEMS and PAST PSYCHIATRIC HISTORY

What are the primary reasons for seeking treatment?

____

____

Have the client ever been to counseling? Yes No If so, when and where?

____

For what reasons did the client previously seek help?

____

PERSONAL AND FAMILY MEDICAL HISTORY

List all current Medications (including dosages): ____________________________________

____

List all past psychiatric medications: ____

____

Has client ever had a significant head injury? Yes No When? ______________________

How many hours of sleep does the client get per night? __________________

What medical issues is the client currently receiving treatment for (i.e. diabetes, epilepsy, etc.?)

____

What significant medical issues has the client been treated for in the past? _________________

____

Are you aware of any developmental deficits? Yes No Explain: ______________________

____

Any family history of mental health issues? Yes No Explain: ________________________

____

Does the client drink alcohol? Yes No Kind/Amount/Frequency? __________________

Does the client smoke cigarettes? Yes No Amount/Frequency? _____________________

Does the client use recreational drugs? Yes No Amount/Frequency? _________________

History of drug/alcohol addiction? Yes No Explain: __________________________________

Have the client ever been incarcerated? Yes No When? _______________

Charges: ____
Is the client currently on parole/probation? Yes No Explain: _________________________
Parole/Probation Officer's Name:
____

PERSONAL, FAMILY, and SOCIAL HISTORY

Marital Status: ___ Married __ Never Married ___ Separated ___ Divorced __NA (minor)
___ Widowed ___ Common Law ___ Partners ___ Engaged

Spouse/Partner's Name: ________________________________ Spouse/Partner age: _____

How long have you been in your current relationship or marriage? _____________________

What are the names of your previous spouses and how long were you married? ___________
____

Names and ages of children with current spouse/partner: _____________________________
____

Names and ages of children from previous relationships/marriages: _____________________
____

Highest education level (i.e. degrees, certificates, years of education)? ___________________
____

Current occupations: _____________________ Spouse/Partner occupation: _______________

What are the clients greatest fears? ____
What does the client consider their greatest strengths? ___________________________________
____
What do you consider your greatest weaknesses? _____________________________________
____
What would the client like to accomplish in therapy? What are the client's goals?
____
____
What is your presenting problem? (What brought you in today)?
____
____

BY SIGNING BELOW, YOU INDICATE THAT THE INFORMATION PROVIDED IN THIS FORM IS TRUE AND ACCURATE TO THE BEST OF YOUR KNOWLEDGE.

____ _______________________
Client Signature Date

____ _______________________
Parent/Legal Guardian Signature Date

Wetzel Counseling

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POLICIES, GENERAL INFORMATION AND CONSENT FOR TREATMENT OF PSYCHOTHERAPY SERVICES

INSTRUCTIONS: Please read the following carefully and initial each of the paragraphs where indicated.

______ **CONFIDENTIALITY:** All information disclosed within sessions and the written records pertaining to those sessions are *confidential* and may not be revealed to anyone without your (client or parent's) written permission, except when required by law. The following are exceptions or **LIMITS TO CONFIDENTIALITY:**

- **Duty to Warn and Protect**
  When a client discloses intentions or a plan to harm themselves or another person, the mental health professional is required to report this information to the proper legal and/or medical authorities.
- **Abuse of Children and Vulnerable Adults**
  If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult) or a child (or vulnerable adult) reports information that indicates actual or possible abuse and/or neglect the mental health professional is required, by law, to report this information to the appropriate social service (such as Child Protective Services) and/or legal authorities.
- **Minors/Guardianship**
  Parents or legal guardians of non-emancipated minor clients have the rights to access the clients' records.
- **Subpoena by Judge**
  If a judge issues a subpoena for the client records then they must be released to the judge.
- **Third-Party Payers**
  Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

______ **CONFIDENTIALITY OF COMMUNICATION:** E-mail, fax and phone communication can be relatively easily accessed by unauthorized people and thus compromise your confidentiality. The client must notify the therapist if they decide to avoid or limit the use of any or all of these modes of communication.

______ **CONSULTATION:** Consultation with other healthcare providers may occur in order to ensure the quality of the counseling service; however, a client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

______ **HEALTH INSURANCE & THIRD-PARTY PAYMENT:** Complete session fees will be due on the date of service unless previous arrangements are made with the therapist or third-party payers. Insurance companies and third-party entities may vary in their coverage of specific issues addressed in psychotherapy. It is your responsibility to verify the specifics of your coverage. **In the event that your insurance or third-party payer does not pay for services, you will be responsible to pay any unpaid balance.**

______ **EAP (Employee Assistance Programs):** I will accept one EAP referral for therapy per calendar year. After the number of EAP sessions are met for that calendar year, clients will need to pay out of pocket or utilize their health insurance plan to continue therapy. EAP's are not designed to treat mental health diagnoses but to provide preventative, short-term counseling.

______ **PAYMENTS & FEES:** Payment in the amount of your fee is due by the end of each session unless prior arrangements have been made. Acceptable methods of payment are cash, check, and credit card. Standard fees are $150 per 55-minute session and $150 for the first initial session unless a separate pay arrangement has been made with the therapist. A fee of $35 may be assessed for returned checks. If a check is returned for insufficient funds, checks will no longer be allowed as a method of payment. **Patients using private insurance to help with the cost of treatment will be responsible for all amounts due as stated by the insurance company to include copays and deductibles**. Patient gives permission to allow the therapist to bill their insurance company for services rendered. **Patients will be required to pay for the sessions if their private insurance company is not accepted by the therapist or if there is a denial in the claim or if there is a discrepancy in the claim resulting in a payment deficit.**

______ **FEE AGREEMENT:** I understand that my fee for services per 55-minute session will be $150 per session and $150 per initial session if paying out of pocket (not using insurance) or the fee will be whatever the copay and/or whatever the insurance states is due for the private insurance held by the patient. **All appointment cancellations require a 24- hour advanced notice. In the event that the patient cancels without a 24-hour notice or is a no show to their appointment, they will be charged one half of the session fee for the first cancellation/missed session and the full price of a regular session for any cancellations/missed sessions after. This fee is based upon the rate that the insurance reimburses for sessions for clients using insurance and the out of pocket rate for clients not using insurance .** If an arrangement for cash sessions (not using insurance) is made with the therapist then the fee for services per 55-minute session will be $______ per session and $_____ per initial session which will be arranged with the therapist during the initial phone call and will be filled in here by the therapist and initialed by the therapist during the first session.

______ **CARD PROCESSING:** I give permission for Misti Wetzel to run my card on file, for any amounts due to include missed session and late cancellation fees. If you do not wish to save a card on file, by initialing here, you agree to pay the amounts due upon receipt of an Invoice/Statement of amounts due, within 48 hours unless prior arrangements have been made.

______ **CANCELLATIONS:** If you need to change or cancel an appointment, I require that you **notify me at least 24 hours in advance.** You will be personally charged up to one-half the current hourly fee for the first missed/late cancellation (cancellations not made within 24 hours of scheduled session time) and will be charged the full hourly fee for the second missed/late session and any sessions thereafter. The therapist will wait up to 10 minutes after the scheduled session time and has the right to terminate the session after 10 minutes past the scheduled session time if client has not shown or made contact with the therapist. Anything after 10 minutes past

the scheduled session time is considered late and is subject to a late cancellation fee which is up to one-half the current hourly fee for the first missed/late session and he full fee for any late/missed sessions thereafter.

______ **RIGHT TO REVIEW RECORDS:** Both law and the standards of my profession require that I keep appropriate treatment records. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when releasing such information might be deemed harmful in any way by the therapist. In such cases, I will provide the records to an appropriate and legitimate mental health professional of your choice. Considering the above exclusions, if appropriate and upon your written request, I will release information to any agency/person you specify unless I assess that releasing such information might be harmful in any way.

______ **THERAPY PROCESS:** Participation in therapy can result in a number of benefits to you including improving relationships and resolution of the specific concerns or symptoms that led you to seek therapy. Working towards these benefits requires effort on your part both in and outside of sessions. Although therapy has been shown to improve relationships and symptoms, it may create uncomfortable feelings in the short-term. An example would be remembering or talking about unpleasant feelings, events, or thoughts can result in experiencing discomfort or strong feelings or anger, sadness, worry, insomnia, etc. Please inform me if such issues arise. I cannot guarantee what you will experience or the benefits you might receive however; it is most likely to be successful with your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. I will ask for your feedback and views on your experience in therapy and will welcome your honest response. During the course of therapy, I'm likely to draw from various psychological approaches according to the problem that is being treated and my assessment of what will best benefit. These approaches include cognitive behavioral, solution-focused, family systems, or psycho-educational therapy.

______ **MINOR CLIENTS:** Parents/Legal Guardians have a right to received progress reports on their child's counseling **however; personal information shared by a child during an individual session will be kept confidential unless it involves imminent danger to the child or someone else.** Young people will not confide in a counselor if they believe that personal information will be revealed to their parents. **If applicable, I must receive a copy of the most recent divorce decree or custody order at our first session.** This is to ensure proper consent, confidentiality, and disclosure of information. All parent/guardian parties must at least be informed of treatment, which is the responsibility of the client's guardian bringing the client to session, and one of more guardians with custodial rights must consent to treatment of the minor at, or prior to, the first session.

______ **DURATION & TERMINATION:** The duration of treatment depends entirely on your presenting concerns, treatment goals, and effort toward those goals in and outside of sessions. I typically discuss duration more specifically with the client in the 3rd or 4th session, depending on factors such as duration limitations by your insurance carrier. If in treating you, I find any conflicts of interest, or an area that is out of my scope of practice, feel it would be unethical to continue treating you, I will refer you out to another therapist and/or agency.

______ **LATE ARRIVALS:** Sessions must end on time even in the case of late arrivals. This is to ensure timely sessions for the following clients and their upcoming sessions. Session fees remain the same fee even if the session is shorter due to late arrivals (up to 10 minutes late).

______ **LITIGATION LIMITATION:** Due to the sensitive nature of therapy and the information shared and addressed, **you agree that I am not obligated to supply any documentation, correspondence, or presence regarding any legal proceedings**. Should you or your attorney desire any documentation or service for court/legal purposes, **I must receive such request in writing and will have 2 weeks to give a response.** I may decline the request if disclosure of the requested information may be harmful in any way to the client; no request will be acknowledged unless it is accompanied by the client's written permission. Any documentation, consultation, or testimony requests will incur a charge of $100 per half hour. Testimony charges may include time spent traveling, preparing reports, attendance, and other case related costs.

_______ **TERMINATING TREATMENT:** You have the right to terminate counseling at any time. However, if you decide to terminate your treatment, you will be encouraged to talk with your therapist about the reason for your decision so that sufficient closure to your treatment can be made. In your final session your progress and ways in which you can continue to utilize the skills and knowledge you gained through your therapy can be discussed. Any referrals needed will also be discussed at that time.

_________ AFTER HOURS EMERGENCIES: If you have an after-hour emergency, or if you need immediate assistance, call 911, your primary care physician, or visit your local emergency room.

_______ ETHICAL GUIDELINES: The therapist working with you is governed by the Code of Ethics of the Texas State Board of Examiners of Professional Counselors. Should you have any complaints, please submit those to this Board by telephone at (800) 942-5540 or in writing at 1100 West 49th Street, Austin, TX 78756-3183. Please keep a copy of this form for future reference.

______ **MEDIATION & ARBITRATION:** Any disputes in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of initiation of arbitration. The mediator must be a neutral third party chosen by agreement of me and the client(s). The cost of such mediation, if any, shall be split equally. In the event that mediation is unsuccessful, any unresolved controversy related to the agreement should be submitted to and settled by binding arbitration in your county in accordance with the rules of the American Arbitration Association in effect at the time the demand for arbitration is filed. If your account is overdue by more than 60 days and there is no agreed payment plan, I may use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection shall be entitled to recover a reasonable sum as and for attorney fees. In the case of arbitration, the arbitrator will determine the sum.

CONSENT TO COMMUINCATE WITH CURRENT TREATING PHYSICIAN:

YES or **NO** I agree and give written consent for Misti Wetzel, LMFT, to be able to communicate with my treating physician for a greater continuance of care. A separate HIPAA form will be filled out to grant permission.

CLIENT/GUARDIAN: I have carefully read, understand, had any questions answered, and agree to comply with the above policies and information and consent for treatment and psychotherapy services with Misti D. Wetzel, LMFT and I agree to participate in the prescribed plan of treatment.

Client name (Print): ____ Date: ____________

Signature: ____

Parent/Guardian Name (Print): _______________________________ Date: ____________

Signature: ____

I have discussed the above issues and policies with the client. My observations of this person's behavior and responses give me no reason to believe that he/she is not fully competent to give informed and willing consent to treatment.

Signature: ____ Date: ____________
Misti D. Wetzel, LMFT

Acknowledgment of HIPAA Compliance

HIPAA, The Health Insurance Portability and Accountability Act, was enacted by congress to protect your personal health information. It is a set of regulations that guides the way healthcare information is stored and shared. This includes how disclosures are made. It is intended to protect your private medical information. The State of Texas and the Texas State Board of Examiners of Licensed Professional Counselors code of ethics and the Texas State Board of Examiners of Marriage and Family Therapists have long established standards which meet and in many cases exceed HIPAA standards. Misti D. Wetzel has and will continue to comply with all ethical and legal guidelines in the state of Texas that apply to mental health counseling, and with the newly enacted Federal HIPAA regulations.

Following are circumstances in which your personal health information may be used:

1. In accordance with HIPAA, your information may only be released with your consent.
2. All of your counseling sessions will become part of your clinical record. The communication is privileged. Anything you say to your therapist is confidential, with exceptions that include but are not limited to the occurrence of any of the following situations: 1) you authorize your counselor to disclose information to any third party, such as consultation with another professional; 2) the counselor is ordered by a court of law to disclose your information; 3) the counselor determines that you pose a danger to yourself or to others; 4) the counselor becomes aware of any abuse (physical or sexual) including neglect which involves a child, an aged adult, or a person who is disabled.
3. Your records will be maintained for a period of seven years (for children this means seven years beyond the age of 18). Client files are stored in dual-lock storage. All electronic data is password protected.
4. No 'Quality Improvements' will be performed on your file by anyone other you're your counselor. Any business agent, such as a receptionist, is bound to strict confidentiality and is punishable by law for any infringement upon confidentiality clauses.

If you have any questions, please feel free to speak with your counselor directly. Always ask questions! Once you have read and have an understanding of the above information and HIPAA, please sign and date below. If you have any further questions regarding HIPAA you may visit www.hhs.gov/ocr/hipaa or call directly 1.800.627.7748.You may also email questions to: ocrprivacy@os.dhhs.gov

____ ____________________

Signature of Client / Legal Guardian | Date

____ ____________________

Printed Name | Relationship to Client