# Client Information

Initial Appointment Date: ____/____/____

First Name: ____________________Middle Initial: ______Last Name: ____________________

Date of Birth:_________________________Social Security No.: __________________________

Sex: ________Marital Status:__________________Religion: ____________________________

Address: ____________________________City: ____________________Zip:_______________

Employer or School: _______________________________Full time: _______Part time: ______

Phone Numbers:
Work ( ______) ____________ Home ( _____ ) _______________Cell ( _____ ) ____________

Circle the preferred Phone Number: Home Work Cell

Email: ____________________________________

How did you hear about us?: ______________________________________________________

**EMERGENCY CONTACT**:
Full Name: __________________________Contact Phone Number: ( ______) ______________
Address: _________________________________________________________________________
Relationship to Client:____________________________________________________________

# Confidential Client Information

Client Name: ________________________________

Children or Siblings (name, ages):

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Are you currently receiving treatment for an illness, injury, or other medical condition?
Yes or No
If yes, what is the diagnosis and what are the treatments?

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Are you currently taking any prescription or over-the counter medications or illegal drugs?
Yes or No
If yes, please tell us the name and dosage of each medication.

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Legal Issues and History: Please tell us if you have any current legal issues (arrests, convictions, civil or criminal lawsuits, judgments, order of protection, bankruptcy, juvenile delinquency).

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

What are your goals for therapy?

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

The above information is true and correct to the best of my knowledge.

___________________________________________ ___________

**Signature of person completing form** **Date**

Circle your relationship to client: Self Parent Spouse Other

# PRE-AUTHORIZATION FOR HEALTH CARE

## CONSENT FOR TREATMENT

By signing this document, I, ________________________________, am indicating that I agree to participate in the following services with Donna Scheffler, LPC-Intern:

____ CLINICAL ASSESSMENT
____ CLINICAL ASSESSMENT FOR MY CHILD
____ FAMILY THERAPY OR COUPLE/RELATIONSHIP THERAPY
____ OTHER ___________________________________________
____ INDIVIDUAL THERAPY
____ THERAPY FOR MY CHILD
____ GROUP THERAPY

I understand that, in order to develop the therapist-patient relationship and treatment plan necessary to meet my needs, an initial assessment will be completed and a joint decision made to either proceed with the recommended treatment plan or to continue the assessment over additional visits. The limitations and benefits of all therapy or services I may receive will be discussed with me. I understand that while the long term goal of therapy is to feel better, I may experience a period of feeling worse before I begin to feel better and I also understand that there is no guarantee of success. I understand that there may be alternative methods of therapy for my consideration and I am encouraged to ask questions regarding my treatment or other methods at any time.

## PRIVACY (CONFIDENTIALITY) POLICY

State and federal laws protect the confidential nature of the therapist-client relationship. Clinical information will not be released to anyone without prior written consent to do so by the client (or the guardian-parent of a minor). However, there are some exceptions where information may be released without client consent. Instances where information may be revealed include:

1) A therapist must take appropriate action when there is a danger to the client or to another individual at the client's hands. In general, this means that the therapist may involve others to protect the client if he or she is suicidal or is unable to provide self-care at a level necessary for basic survival. Others may also be involved to prevent harm to another person. State law mandates that suspected neglect or abuse of a child, of an elderly individual, or of a disabled individual must be reported.
2) When ordered by a court to do so, a therapist may testify or release client records. However, no release of information or testimony is given in response to a subpoena without the client or client guardian's written authorization unless required by law to do so.
3) Consultation with other health care professionals may be necessary at some point in time. Where possible, identification of clients is withheld. However, there are times when exchange of information is necessary. An example of this type of exchange would be when the therapist is out of town or on vacation and another therapist is providing coverage for that therapist. Case material is often used for training, for research, and for other academic endeavors but client identification is always removed. Any other release of information must come with the above listed written approval.

I understand that this agreement is valid for the duration of time that I am participating in services with Donna Scheffler, LPC-Intern (hereinafter DS). By signing below, I acknowledge that I have received a copy of the ***Pre-Authorization for Health Care*** and the ***Privacy (Confidentiality) Policy***, and I understand and agree to the entire contents of those documents. I acknowledge that I have had an opportunity to have answered any questions, comments or concerns that I might have had prior to signing this consent and participating in services. I am aware that I can stop counseling at any time. DS reserves the right to amend the ***Pre-Authorization for Health Care*** and the ***Privacy (Confidentiality) Policy*** and changes will be available at the office of DS. I can request a copy of changes at any time at no charge. Any changes that DS makes are effective immediately unless otherwise indicated. **A COPY OF THIS PAGE MAY BE FOUND ON THE LAST PAGE.**

_____________________________________________ ______________

CLIENT SIGNATURE (18 and older) Date

_____________________________________________ ______________

SIGNATURE OF PARENT OR SPOUSE Date
(for a child age 17 or younger)

# Notice of Financial Responsibility

I understand that I will be charged $100 per session. **<u>I am responsible for payment at the time of the session. If I do not give 24-hour notice of a cancellation or if I miss my appointment, I will be charged the full session fee.</u>**

I understand that payment may be made with cash or by check. DS does not extend credit. In any such arrangement, late payment fees of $10 per month will be charged on any balance not paid within 30 days. DS does not depend on an outside collection service unless accounts are overdue by 90 days. DS would much rather communicate with patients and find solutions to overdue accounts. I hereby consent to the delegation of collection activities to an outside collection agency, including the release of necessary information required by the collection agency. A delinquency fee of 40% of the outstanding balance will be added if a collection agency is required. There is a returned check processing fee of $25 in addition to reimbursement for charges assessed by DS's bank. Statements, receipts, or other documentation will not be issued to any delinquent account until paid in full. I agree that DS reserves the right to amend this agreement and may provide me with written notice of any amendment, at which time I will have 30 days to decide if I will continue services with DS under the amended agreement. I authorize payment of benefits to DS for any and all services provided by DS.

**COURT APPEARANCES:** I understand that if report preparation is requested or required, the time rate charged for our therapy sessions will apply. Extended or frequent telephone contact will also be charged for. I will not agree to court appearances or other legal involvements unless we have discussed the matter thoroughly and both agree that such involvement is within my range of competence and will not interfere with the treatment relationship. Professional fees for court appearances, depositions and attorney consultations are $125 per hour including travel and waiting time, are non-discountable, and are payable in advance only. A four-hour minimum ($500) is required and must be paid prior to any testimony, provision of a clinical opinion, response to attorneys via telephone call or mail, subpoenas, or preparation of any report for litigating parties.

_____________________________________________ ______________

Signature of Client of Parent of child under 17 Today's Date

**RELEASE OF INFORMATION:** I authorize any and all of my medical information necessary to process insurance claims to be released to _______________________________________ for the purpose of processing claims.

_____________________________________________ ______________

Signature of Client of Parent of child under 17 Today's Date

## Credit Card Information and Authorization

If you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise you will be charged at my full hourly rate. If I do not hear from you before your missed appointment, your credit card will be charged. If you need to cancel or are going to be late, please call me at my office number (830-392-0475). Please note that this number *does not* receive text messages. If you arrive late, the session will still end at the scheduled time. If I haven't been informed that you will be late and you haven't appeared 15 minutes after your scheduled time, I may leave the office.

Credit Card Authorization

I, __________________________, hereby authorize Donna Scheffler, LPC Intern to bill my credit card as listed below for professional fees for [ ] myself or _______________________.

(Initial)
_____ Appointments that I elect to pay by credit card.
_____ Missed appointments. (Will be charged at the full fee)
_____ Appointments I have cancelled with less than 24 hours' notice. (Full fee)

I also agree that my credit card may be charged for the following:
_____ Balances of charges not paid by me.
_____ Insufficient funds/returned checks and bank charges for those.

Type of Card (check one):

[ ] Visa [ ] Mastercard [ ] Discover [ ] American Express

Name as it appears on card: _______________________________

Card number: ___________________________________

Expiration Date: ____________________________

CVV2/CID Security Code: _____________________________

Zip code on billing address: _____________________________

Credit card charge will appear as Jay Jeter.

Signature: ______________________________________

Date:______________________________

# LPC Intern Counseling Agreement

Donna Scheffler, LPC Intern
Supervised by Jay Jeter, LPC-S

Please initial the following statements to acknowledge your understanding:

_____ I understand that Donna Scheffler, LPC Intern is a Licensed Professional Counselor Intern in the state of Texas under the supervision of Jay Jeter, LPC-S.

_____ I understand that Donna Scheffler works with children, adolescents, and adults in individual, group, and family counseling.

_____ I understand that as my therapist, or the therapist working with my child, I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.

_____ I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed with that assignment.

_____ I understand that if I am concerned about slow progress or lack of progress, I have the right to speak to Donna Scheffler and/or Jay Jeter.

_____ I understand that Donna Scheffler does not perform formal testing, but can make referrals to those who do upon request.

_____ I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.

_____ I understand that there are some occasions when confidentiality can/must be breached. Those are: a) Under my direction Donna Scheffler may share information with someone else either in writing or verbally, b) Donna Scheffler determines that her client poses a threat to themselves or others, c) Donna Scheffler is ordered by a court to disclosed information, or d) Donna Scheffler suspects that abuse of a child, an elderly individual, or a disabled individual has taken place, at which time she will notify Child/Adult Protective Services.

_____ I understand that counseling can improve as well as upset the equilibrium in any person or family.

_____ I understand that if I have a complaint I cannot resolve with Donna Scheffler and I wish to file a formal complaint, I may contact the Texas State Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

_____ I understand that there is a returned check fee of $25 and that if a returned check is not cleared up in 30 days, Donna Scheffler will file suit with the Comal County District Attorney's Office.

_____ I understand that payment is due at the time of the service.

_____ I understand that if I do not give at least 24 hours notice in cancelling an appointment, I will be charged a fee equal to that of the scheduled appointment. This fee will be due no later than the next scheduled appointment.

_____ I understand that the rate for all counseling sessions is $100.

_____ I understand that Donna Scheffler is not a psychiatrist, she is a Master's level therapist, and as such cannot recommend or prescribe medications, but can encourage clients to see an MD for a medication evaluation.

_____ Emergencies: I understand that although Donna Scheffler does not provide formal emergency services, she does wish to be available to the extent possible. I may call the office number at any time and leave a message. If during the business day, this call will be returned fairly quickly in most circumstances. If the call is received over night or on the weekends, it will usually be returned the next business day. If I find myself in an urgent situation, I have the choice of waiting for the return call, of calling 911, or going to the nearest emergency room for immediate care.

_____ Death or Incapacity: I understand that in the event Donna Scheffler dies or becomes unable to continue providing clinical services, Jay Jeter, LPC-S will be designated as conservator for my patient records and he will take possession of said records at that time. Upon receipt of my written request, Jay Jeter, LPC-S will make these records available to me or a mental health provider of my choice.

***By signing below, I confirm that I have read, agree to, and received the above information.***

_____________________________________________ ____________________

Client Signature (or Legal Guardian) Date Received and Read

_____________________________________________

Printed Name

This copy is for you to read, understand, sign, and leave with Donna Scheffler.

# LPC Intern Counseling Agreement (Client Copy)

Donna Scheffler, LPC Intern
Supervised by Jay Jeter, LPC-S

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# PRE-AUTHORIZATION FOR HEALTH CARE (Client Copy)

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CLIENT SIGNATURE (18 and older) Date

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SIGNATURE OF PARENT OR SPOUSE Date

(for a child age 17 or younger)