COULTER FAMILY COUNSELING, PLLC
LEANNA COULTER, MA, LPC
(830) 624-4774

Individual Counseling Intake Form

Today's Date _____

Home Phone _____

Cell Phone _____

Work Phone _____

Client's Name_____

Address _____City _____State _____Zip _____

E-mail_____

Age _____ Date of Birth _____

Where would you like me to leave you messages?

❑ Home ❑ Work ❑ Cell ❑ None

If there is an emergency at the office and we must cancel your appointment, where should we call? ❑ Home ❑ Work ❑ Cell ❑ None

Client Occupation_____

Emergency Contact _____Phone Number_____

Are you currently in counseling elsewhere? ❑ Yes ❑ No ***If yes, please stop here and speak with LeAnna before completing the remainder of the form.***

How were you referred to my office?_____

_____

Relationship Status: ❑ Single ❑ Married ❑ Cohabitating

❑ Committed Relationship ❑ Engaged ❑ Separated ❑ Divorced ❑ Widowed

How long have you been in this relationship? _____

Please list your children and their ages _____

_____

_____

_____

Briefly describe your hopes from counseling _____

_____

_____

_____

Health and History Information:

Who is your doctor? _____When was the last visit? _____

Any concerns shared by the doctor?

_____

May LeAnna Coulter, MA, LPC contact your medical doctor in order to coordinate your treatment? ❑ Yes ❑ No (A separate Release of Information form will be requested.)

Describe any allergies you have:

_____

Do you have a mental health diagnosis? If so, which one

_____

Are you under the care of a Psychiatrist? If so, whom _____

Have you been prescribed any psychotropic drugs by your Psychiatrist? ❑ Yes ❑ No

List all medications or drugs (legal or illegal) you have taken in the last year

_____

List any significant illnesses, important accidents and injuries, grief and loss, or any other major changes or events you feel I should be aware of _____

_____

_____

Please answer the following:

Have you ever attempted suicide or harmed yourself in any way? ❑ Yes ❑ No

Have you had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way? ❑ Yes ❑ No

Are you currently having any thoughts about harming yourself or others? ❑ Yes ❑No

Are you having any thoughts that are scaring you? ❑ Yes ❑ No

Please elaborate if necessary: _____

_____

_____

_____

Professional Disclosure Statement And Informed Consent

PLEASE INITIAL EACH ITEM:

_____ I understand that LeAnna Coulter, MA, LPC is a Licensed Professional Counselor #71387 in the state of Texas. LeAnna Coulter, MA, LPC facilitates the counseling process with cognitive behavioral, interpersonal, supportive therapy models and Gottman Method RelationshipTherapy.

_____ I understand that LeAnna Coulter, MA, LPC does not provide 24-hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1 or go to an emergency room for assistance.

_____ I understand that during the time that we work together, we will meet weekly for approximately 45-60 minutes. While our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one.

_____ I also understand our contact will be limited to counseling sessions except, only in cases of emergency, or the need to cancel or reschedule, I will call LeAnna Coulter, MA, LPC at (830) 624-4774.

_____ I understand that, at any time, I may initiate a discussion of possible positive or negative effects of entering into the counseling relationship and that specific results are not guaranteed although benefits are expected from counseling.

_____ I understand that counseling can improve as well as upset the equilibrium in any person or family. Counseling is a personal exploration and may lead to changes in my life perspectives and decisions. These changes could be temporarily distressing.

_____ I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship. If at any time I am dissatisfied with LeAnna Coulter, MA, LPC's services as a therapist, I have a right to let her know. If I do not feel that LeAnna Coulter, MA, LPC may resolve my complaint, I may file a formal complaint through contact with the Texas Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

_____ I understand that our paths may cross in social situations but that our therapeutic relationship comes first, along with protection of my confidentiality, and that LeAnna Coulter, MA, LPC does not initiate the greetings.

_____ Should I believe that a referral is needed, LeAnna Coulter, MA, LPC will provide some alternatives including programs and/or people who may be able to assist me.

_____ I understand that the rate for an individual counseling session is $105.00 for a 45-minute session and $135.00 for a 60-minute session.

_____ I understand that the rate for a postpartum home visit is $125.00 for a 45-minute session and $145.00 for a 60-minute session. I will make home visits to clients if they are established clients prior to the home visit.

_____ I understand that all fees for counseling are due after each session.

_____ I understand that the rate for all subsequent therapy services such as: attending parent/teacher conferences, attending ARD meetings, conducting classroom observations, participating in legal depositions, interactions with insurance companies, phone calls over 5 minutes, etc. will be billed at $135.00 per hour in 10-minute increments.

_____ I understand that conducting expert witness and testimonial services is not an area of interest of LeAnna Coulter, MA, LPC and should I subpoena LeAnna Coulter, MA, LPC as a factual case witness or involve her in any court-related processes, LeAnna Coulter, MA, LPC charges a retainer fee of $1,500.00, with an additional $240.00 every hour she is involved in legal depositions, case preparation, travel, and witness time.

_____ I understand that if I do issue LeAnna Coulter, MA, LPC a subpoena without her approval (see above) that my subpoena will be directly turned over to an attorney and a bill will be rendered to me for immediate retainer fee payment.

_____ I understand that if a check is returned, a processing fee of $25.00 will be assessed to my account. Additionally, I will need to make a cash or money order payment for the returned check and $25.00 processing fee. After a returned check, the office of LeAnna Coulter, MA, LPC may require cash payment of future appointments.

_____ I understand that if a returned check is not cleared up in 30 days, LeAnna Coulter, MA, LPC will file a suit with the Comal County District Attorney's Office.

_____ **I understand that I am responsible for any appointments that are not canceled at least 24 hours prior to my appointment time, with the EXCEPTION OF AN EMERGENCY.**

_____ **I understand that if I do not cancel my appointment 24 hours ahead of time, the fee for calling to cancel on the day of my appointment is half the session fee.**

_____ **I understand that if I do not show up for an appointment it will result in my being charged full session fee for the full missed session.**

_____ I understand that my records and all of our communications become part of the clinical record. Records are the property of LeAnna Coulter, MA, LPC. All client records are disposed of five (5) years after the client has stopped receiving services. In the case that I am incapacitated, death or loss of license, your records will be boxed and placed in the care of Walter Nickells, DC.

_____ I understand that while most of our communication is confidential there are, however, circumstances when disclosure can occur without my prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

- You are a danger to yourself or someone else.
- In situations of suspected child or elder abuse, it is the duty of the mental health provider to notify medical, legal, or other authorities.
- You disclose sexual contact with another mental health professional.
- If you are involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
- LeAnna Coulter, MA, LPC is ordered by a court to disclose information.
- You direct LeAnna Coulter, MA, LPC in writing to release your records.
- LeAnna Coulter, MA, LPC is otherwise required by law to disclose information.

STATEMENT OF UNDERSTANDING

I have read the above and understand the nature of service providers and the Limits of Confidentiality outlined above and I solemnly swear that all of the above information is true to the best of my knowledge

_____ _____

Client Signature Date

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AGREEMENT FOR THERAPY

I,_____

❑ Agree to receive therapeutic services provided by LeAnna Coulter, MA, LPC.

❑ I have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both myself and my family.

❑ Furthermore, I understand that I am expected to be an active participant in this process.

❑ I acknowledge that I have received and understand the Notice of Privacy Practices for this office.

❑ My signature below means that I understand and agree with all of the points above.

_____ _____

Client Signature (parent or guardian if minor patient) Date

HEALTH PROVIDER'S STATEMENT

I have inquired to insure that the patient understood the above description of the limits on confidentiality.

_____ _____

Health Provider's Signature Date

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HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.
Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I acknowledge that I have received and understood the HIPPA Notice of Privacy Practices for this office:

_____ _____

Client signature Date

Consent for Use and Disclosure of Health Information:

I hereby permit and release LeAnna Coulter, MA, LPC to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs,managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

_____ _____

Client signature Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent