

CLIENT INFORMATION

Name: _____

Date of Birth: ____/____/____ Age: _____ SS#: _____ - _____ - _____

Spouse's Name: _____ Spouse's Date of Birth: ____/____/____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Other: _____

Email Address: _____

Gender: _____ Male _____ Female Ethnicity: _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

Employment Status: __ Full-Time __ Part-Time __ Student __ Unemployed __ Disabled __ Other

Employer: _____ Position/Occupation: _____

Primary Care Physician/Psychiatrist: _____ Phone #: _____

Do You Want Information Released To Your Doctor? _____ Yes _____ No

If Yes, Please Provide

Address: _____

Emergency Contact Name & # _____ Relationship to Client: _____

Who referred you: _____

***Financial Agreement and Authorization assignment of insurance benefits: payment is requested at the time services are rendered unless other financial arrangements are made. I understand that I am responsible for any health insurance deductibles or copayments. I give full consent for completion of an evaluation and the provisions of ongoing mental health treatment as necessary until I otherwise notify this clinician. I agree that the information above is accurate and complete to the best of my knowledge.**

Client (Or Guardian) Signature: _____ Date: _____

Acknowledgement and Understanding

Please review this information and ask about anything you do not fully understand.

Benefits and Emotional Risks:

The majority of individuals and families that obtain behavioral health services benefit from the process. The therapeutic process is generally quite useful, but some risks do exist. As counseling begins, please understand that some experience unwanted feelings, and that examining old issues may produce unhappiness, anger, guilt, or frustration. Important personal decisions are often an outcome of counseling. These are likely to produce new opportunities as well as unique challenges. Sometimes a decision that is positive for one family member will be viewed as negative by another. Don't hesitate to discuss treatment goals, procedures or your impressions of the services that are being provided. Counseling is voluntary and you have the right to end services at any time.

***Length of Services:** Counseling often involves regular weekly sessions that are 45 to 50 minutes in length. The number of visits depends on the nature of the problem and your individual situation.

***Hours/Availability:** Office hours are variable throughout the week, except for legal holidays. In the event that a crisis occurs and Ms. Crochet is unavailable, contact the mental health hotline at 472-HELP, your primary care physician, call 911 or go to the closest emergency room.

* There is a \$35 charge on all returned checks. NSF checks must be replaced with cash, certified check or money order. Delinquent accounts will be referred for collection and credit reporting as well as interest added to balances over 60 days.

***24 Hour notice by phone is required if you need to change or cancel a therapy appointment. You will be charged the \$125/hr. individual therapy rate for the missed appointment or late cancellation. Insurance will not cover this fee.**

***Regarding Client Litigation:** Ms. Crochet will not voluntarily participate in any litigation, or custody dispute in which the client and another individual, or entity, are parties. Ms. Crochet has a policy of no communication with the client's attorney and will generally not write or sign letters reports, declarations, or affidavits to be used in the client's legal matter. Ms. Crochet will generally not provide records or testimony unless compelled to do so. Should Ms. Crochet be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving the client, the client agrees to reimburse Ms. Crochet for any time spent for preparation, travel, or other time in which she has made herself available for such an appearance at the usual and customary hourly rate of \$375. Ask for detailed list.

I/We the undersigned, have read and fully understand the above policies. I/We further agree to abide by the policies set out above. I/We have had a chance to ask my/our counselor for additional clarification regarding these policies.

Signature: _____

Date: _____

Parent/Guardian: _____

Date: _____

CREDIT CARD INFORMATION

Please provide the required information about the credit card you will use to pay any fees for missed appointments or to make payments on your account.

Type of Credit Card: _____ Visa or _____ Master Card

Credit Card Number: _____

3 Digit Security Code on Back of Card: _____ Expiration Date: _____

Name as printed on Card: _____

Billing address for Credit Card: _____

By my signature below, I grant Stacie Crochet, LCSW my permission to charge the account described above for missed session fees.

Signature

Date

CANCELED APPOINTMENTS: Please remember that without a full 24-hours notice, your credit card will be billed for **full payment** of your missed session. A missed session cannot be billed to insurance. If you do have to cancel an appointment, you may leave a confidential message 24 hours a day, seven days a week at 512-921-5925.

Confidentiality Policy

Confidentiality and privileged communication remain the rights of all clients of professional counselors according to law. However, there are limits to such communication some of which are mandated by state law. It is very important that you and those seeking counseling with you carefully read and understand the following limits of confidentiality.

Duty to Warn: Some courts have held that if an individual intends to take harmful, dangerous, or criminal action against another human being, or against himself or herself, it is the counselor's duty to warn appropriate individuals of such intentions. Those warned may include a variety of persons such as: The person or the family of the person who is likely to suffer the results of harmful behavior; the family of the client who intends to harm him/herself or someone else; associates, friends of those threatened, or making threats; and law enforcement and medical emergency officials.

Child Abuse: Texas state law mandates the reporting of incidence of suspected incidence of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agencies.

"Dependent Adult" and Elderly Abuse: Texas law requires the incidence of "dependent adult" or elderly physical abuse reported to your counselor must also be reported to Texas authorities.

Family and Couple Therapy: Family members and couples may be seen at times individually or conjointly. Information shared during these sessions or in related settings (e.g. telephone calls) is considered part of the overall family or couple therapy process and is not confidential from the other participating family members or partners. Ms. Crochet will use her discretion in handling these matters. This is simply a "no secrets" policy. It is important that you understand this policy before treatment begins. It supports the belief that healthy relationships are built on openness and truth.

Case Evaluation: In order to ensure the best treatment possible for each client, Ms. Crochet does consult with other professional counselor regarding cases. This is traditional in both out-patient and in-patient counseling facilities and is referred to as "case conference" or "peer review." If you have any concerns regarding this practice, please notify your therapist.

Neglect of Outstanding Debt: In the event that a client fails to honor, after reasonable efforts to collect; his/her debt, Ms. Crochet may place the account in the hands of an agency or attorney for collection or legal action. This will necessitate the release of pertinent demographic information as well as accounting information. NO THERAPEUTIC INFORMATION WILL BE RELEASED.

Maintenance of records: A written record of contact will be maintained in a locked filing cabinet in a locked office. Records are released only with your written permission. Other than the exceptions noted above, information is released only with your voluntary written permission. I/We the undersigned, have read and fully understand the limits of my/our confidentiality. I/We further agree to abide by the policy set out above. I/We have had a chance to ask my/our counselor for additional clarification regarding the limits of confidentiality.

Signature: _____ Date: _____
Signature: _____ Date: _____

HEALTH HISTORY

Name: _____ Date: _____
 D.O.B. _____

1. Please describe the reason(s) you are seeking treatment:

2. When did the problem begin and what motivated you to seek treatment *now*?

3. On the scale below, please estimate the current severity of the problem(s):

Mildly Upsetting Moderately Severe Very Severe Totally Incapacitating

4. List all past or present mental health treatment:

Dates	Type Of Treatment	Doctor/Therapist Name	Where

5. List all current medications:

6. List all medications taken in the past for emotional/psychiatric reasons and dates taken:

7. Current Alcohol/Drug Use:

How Often:

8. Ever felt suicidal? YES NO
Currently? YES NO

Ever felt homicidal? YES NO
Currently? YES NO

SOCIAL MEDIA POLICY

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

FRIENDING

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

FANNING

I keep a Facebook Page for my professional practice to allow people to share my blog posts and practice updates with other Facebook users. All of the information shared on this page is available on my website. You are welcome to view my Facebook Page and read or share articles posted there, but I do not accept clients as Fans of this Page. I believe having clients as Facebook Fans creates a greater likelihood of compromised client confidentiality and I feel it is best to be explicit to all who may view my list of Fans to know that they will not find client names on that list.

INTERACTING

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact me between sessions, the best way to do so is by phone. Direct email at info@staciecrochet.com is second best for quick, administrative issues such as changing appointment times. See the email section below for more information regarding email interactions.

USE OF SEARCH ENGINES

It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there *might* be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

LOCATION-BASED SERVICES

If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking

enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally “checking in,” from my office or if you have a passive LBS app enabled on your phone.

EMAIL

I prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

CONCLUSION

Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

© Keely Kolmes, Psy.D. – Social Media Policy – 4/26/10

Signature/Date