

Client Information Sheet
Living Well Dallas

Jessica Blue Sky Vigil, Licensed Professional Counselor Intern
Supervised by: Erica S. Gould, MA, LPC, Licensed Professional Counselor #62930

Client Information:

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Home phone _____ Work: _____ Cell: _____

Please indicate where we can leave a message: Home: ___ Wk: ___ Cell: ___

Date of birth: _____ Age: _____

Gender: Male _____ Female _____

Email: _____

Marital Status:

Single: ___ Relationship: ___ Married: ___ Separated: ___ Divorced: ___ Widowed: ___

Name of spouse/significant other: _____

Identify any previous marriages: _____

Identify any history of psychiatric/emotional/drug or alcohol problems and treatments in your current family: _____

and in your family of origin: _____

Primary Care Physician: _____

Emergency Contact:

Name: _____ Phone Numbers : _____

Address: _____ Relationship: _____

Health Information

Please rate your health: Very Good ___ Good ___ Average ___ Declining ___

Recent weight changes: Lost _____ Gained _____

Date of Last physical exam: _____ Report from most recent exam: _____

List all important past or present injuries, illnesses or disabilities:

Are you currently taking any medication? Yes ___ No ___ if yes please list them with dosages _____ Prescribed by: _____

Have you ever used drugs for other than prescribed medical purposes? Yes ___ No ___

If yes please list them _____

Have you ever had a severe emotional upset? If so, please explain: _____

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Other Information

Education (Highest level completed) _____

Have you recently suffered loss from serious personal, social, business, or other issues

Yes _____ No _____

Explain _____

Religious/Faith Background

Current Faith involvement _____

Please explain any recent changes in your spiritual life _____

Personality Information

Have you ever had any counseling or therapy before? Yes ___ No ___

Outcome _____

Please list dates and names of counselors: _____

Have you ever been in a residential or outpatient program for chemical dependency or psychiatric treatment?

Yes ___ No ___ If yes, Please list facility and dates, and indicate if you completed the program successfully:

Please circle any of the following words which best describe you now: active, ambitious, self confident, persistent, nervous, hardworking, impatient, impulsive, moody, often-blue, excitable, imaginative, calm, serious, easy-going, shy, good-natured, introvert, extrovert, likable, leader, quiet, stubborn, submissive, lonely, self conscious, sad, fatigued, anxious, sensitive, other _____

Consent

I have read and received a copy of CLIENT'S RIGHTS AND RESPONSIBILITIES. _____ I hereby consent for therapeutic services provided by Jessica Blue Sky Vigil and Living Well Dallas.

Client's Signature

Date

For minors:

I attest that I am the legal guardian or managing conservator of this minor child, _____, with rights to consent medical treatment for this minor child and I do hereby consent for counseling services to be provided to this child.

Signature of Guardian or Managing Conservator _____

Relationship _____

Jessica Blue Sky Vigil, Licensed Professional Counselor Intern
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CLIENT RIGHTS AND RESPONSIBILITIES:

I am pleased that you have selected me as your counselor. This document is designed to inform you about my background and qualifications as a counselor to ensure that you understand our professional relationship as well as your rights and responsibilities.

EDUCATION:

Master of Arts in Clinical Counseling from Adams State College located in Alamosa, Colorado

Bachelor of Arts in Psychology, emphasis clinical mental health and Bachelor of Science in Sociology, emphasis criminology from Colorado State University - Pueblo.

METHOD OF TREATMENT:

I see counseling as a special and unique relationship between client and therapist. It is important that I meet you, the client, where you are at--meaning, that what works for one client may not work for another. Therefore, counseling will be tailored to meet your individual needs. I also believe that early experiences, in part, help shape the kind of people we are today. This means that as the client, you may spend some time talking about your family of origin and past issues. I am also interested in what you expect from and what you hope to achieve from counseling. I feel that goal setting is an important part of therapy, as it allows both you and I to see and feel what progress is made during the counseling process.

EFFECTS OF COUNSELING:

There is always a risk of psychological side effects from psychotherapy. Sometimes symptoms worsen before they get better. Often times counseling can bring up painful emotions. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

LENGTH OF TREATMENT:

Length of treatment is very difficult to predict. Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. You may end our counseling relationship at any time.

OUR RELATIONSHIP:

Although you will be sharing personal things during the course of counseling, the tie between us is professional rather than personal. It is important to keep this relationship clear, so spending time with you socially or accepting phone calls from you at my home is inappropriate. Sexual intimacy between a counselor and a client is always inappropriate and illegal.

YOUR RIGHT TO PRIVACY:

I will not share the things you tell me without your written permission and I will respect your privacy. However, I may be forced to reveal our communications if:

- I suspect child or elder abuse.
- There is a threat that you will harm yourself or others.
- You become unable to take care of yourself and additional help is needed.

It is important in the field of psychotherapy to consult with other professionals about difficult cases, particularly at this stage of my education and experience. Therefore, it is possible that I will discuss your case with other counselors for the purpose of gaining information or insight about your situation. If this occurs, your name will not be revealed during these discussions.

FEES:

Standard rate for a 50 minute session is \$85.00 (unless you are a member of the Be Well Circle). A sliding scale is available for financial hardship situations. Payment is expected in full at each session. You will be billed for missed sessions unless you call 24 hours in advance to cancel the appointment. (Exceptions can be made for unforeseen and documented events).

EMERGENCIES:

In the event of an emergency, contact your physician, your local emergency room or the local police department when necessary and appropriate. It is your responsibility to seek the appropriate resources in emergency situations.

******I have read the preceding information and understand my rights and responsibilities as a client******

Client signature (Parent/Guardian Signature if client is a minor)

Date

Counselor signature

Date

Complaints may be directed to:

TEXAS STATE BOARD OF EXAMINERS OF PROFESSIONAL COUNSELORS
1100 West 49th Street
Austin, Texas 78756-3183
(512) 834-6658

LIVING WELL

:health & wellness center:

CANCELLATION & RE-SCHEDULING POLICY

We understand that there are times when you will need to cancel and/or reschedule your appointment due to emergencies. We will do our best to accommodate your needs in such situations.

Please know that our policy is to make all cancellations and/or rescheduling requests at least two business days prior to the date of your appointment. As our practitioners are scheduled in hour blocks of time, we request that this policy is honored as strictly as possible. If a previously scheduled session is not cancelled or rescheduled within 24 hours of the time of the appointment, that session will be "missed" and charged for the full session fee.

Thank you for your understanding.

Please sign here indicating that you understand and accept this policy:

Patient Signature

Date

LIVING WELL DALLAS
PH# 972-930-0260 FAX 972-559-3648

Patient Consent and Acknowledgement of Receipt of Privacy Notice
- In accordance with federal Health Insurance Portability and Accountability Act (HIPPA)

I understand that as part of the provision of healthcare services, Living Well Dallas creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a *Notice of Privacy Practices* that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and Practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc .) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or health care operations be restricted. I also understand that the Practice and I must a) agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information and b) agree to terminate any restrictions in writing on the use and disclosure of my protected health information which have been previously agreed upon.
4. My medical and care records may be disclosed to other Living Well Health & Wellness Center providers in order to manage my care including sharing diagnosis, testing results and patient care notes.

I hereby authorize Living Well Dallas and their representatives to be able to discuss my medical status and test results with the following individuals:

Patient's Name (Printed)

Date

Patient's Signature (Or Guardian, if a Minor)