Client Information Sheet

Living Well Dallas | 14330 Midwayd Rd #121 | Dallas, TX 75244
972-930-0260 | www.LivingWellDallas.com
Sara Osterhaus, MA, LPC

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
How did you hear about Sara Osterhaus/Living Well Dallas? ____________________________________
May we send them a thank you note? ______________

I have read and received a copy of CLIENT'S RIGHTS AND RESPONSIBLITIES. __________ I hereby consent for therapeutic services provided by Sara Osterhaus 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___________________

Living Well Dallas
Sara Osterhaus, MA, LPC
Client Rights and Responsibilities

Welcome to Living Well Dallas. In an effort to help you make informed decisions about your therapy, I would like to tell you about my background and qualifications as a therapist and about your rights and responsibilities as a client.

Education & Licensure:

LPC, Licensed Professional Counselor, Texas State Board of Examiners, #61689
Professional Coach Training – Results Coaching Systems, New York, NY
Master of Arts in Counseling, Dallas Baptist University, Dallas, TX
Bachelor of Arts, Exercise & Health Studies, Univ. of Texas at Arlington, Arlington, TX

Method of Treatment:

I use an approach in counseling which addresses the biological, social, psychological, and spiritual aspects of the individual. I take a positive approach to problems, assuming that people are resilient and have tremendous abilities to address their life situations. My method of treatment combines cognitive-behavioral theory with solution-focused ideas. It is my role as a therapist to help you understand the dynamics of your situation and to help you and your family use your particular strengths to address your issues. It is my personal mission to provide an environment of safety, caring, and acceptance to enable honesty, courage, and growth.

I am a Christian psychotherapist. What this means is that my education, skills, and experience are clinical, and my spiritual beliefs are an integral part of who I am. While my beliefs impact and shape the work I do with clients, I often work with clients in therapy who do not share my beliefs. It is my desire to be of help to you regardless of your religious orientation.

Goals, Risks and Benefits:

There is always a risk of psychological side effects from psychotherapy. Sometimes symptoms worsen before they get better. Often therapy brings up painful emotions. Our goal is to confront issues and emotions together, and with time, to work throughout them. Other types or therapy, such as support groups or therapy groups, may also be appropriate in your situation.

Length of Treatment:

Length of treatment is very difficult to predict. Each individual has unique strengths and weaknesses, and each problem is different from the next. It is my goal that each client will finish therapy in a timely manner, without unnecessary waste of time or money.

Fees:

The initial consultation fee is $150, and we will spend about an hour and a half gathering background and setting goals for counseling together. Then, our sessions will be 50 minutes long. Together, we will decide how often you should come. The fee for your sessions will be $115.00, unless other arrangements have been made. You will be billed for missed sessions unless you call 24 hours in advance to cancel the appointment. Exceptions will be made in emergency situations.

Our Relationship:

Although you will be sharing personal things during the course of therapy, the tie between us is professional rather than personal. Sexual intimacy between a therapist and a client is always inappropriate and illegal. If this has happened to you in the past, you should file a complaint with the appropriate licensing agency.

Your Right to Privacy:

I will not share the things you tell me without written permission from you. However, I can be forced to reveal our communications if:

- I suspect child or elder abuse or neglect.
- I feel that there is a threat that you will harm yourself or others.
- There is a licensure board inquiry
- Legal matters are involved.

It is important in the field of psychotherapy to consult with other professionals about difficult cases, therefore, it is possible that I will discuss your case with other therapists and supervisors for the purpose of gaining information or insurance companies will sometimes contact me about the progress of treatment. The release form you sign at the outset of treatment allows me to discuss your case with them. I will respect your privacy within these limitations.

Emergencies:

During office hours, you can reach me at 972-930-0260. In the event of a genuine emergency, you can contact me on my cell phone at 972-333-1097. **Please use this number only if it is an urgent matter**. For medical emergencies, or if you cannot reach me, call 911, 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. If you have any questions regarding your therapy, please feel free to ask.

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

Client signature ______________________ Date ____________

Therapist 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)