Country Place Counseling PLLC

Janet L. Douglas, LCSW, CCH

240 E. Renfro

Burleson, Texas 76028

Telephone: 817-228-4855

Fax: 817-295-7815

CLIENT INFORMATION

Patient Name: _____

S.S.#: _____ Race: _____ Sex: _____ DOB: _____

Address: _____ City/State/Zip: _____

Primary Phone: _____ Okay to leave message at this number? YES NO

Secondary Phone: _____ Okay to leave message at this number? YES NO

Emergency Contact: _____ Cell/Home: _____

PCP: _____ Phone: _____

Who referred you to this office? _____

1st Insurance: _____ Phone: _____

Policy Holder: _____ DOB: _____ Sex: _____

S.S.#: _____ ID#: _____ GRP#: _____

Employer: _____ Phone: _____

2nd Insurance: _____ Phone: _____

Policy Holder: _____ DOB: _____ Sex: _____

S.S.#: _____ ID#: _____ GRP#: _____

Employer: _____ Phone: _____

I hereby assign all medical and mental health benefits to which I am entitled, including private insurance and other health plans, to Country Place Counseling, PLLC and Janet L. Douglas, LCSW. This assignment will remain in effect until revoked by me in writing. A photocopy is considered as valid as an original. I authorize to release all information necessary to secure payment.

Signed: _____ Date: _____

CONFIDENTIAL QUESTIONNAIRE

Fill out the information that applies to you. Leave blank any questions that you do not feel comfortable answering or that do not apply.

Personal Information:

Name: _____ Age: _____

Number of Brothers: _____Number of Sisters: _____Where are you in the birth order: _____

Highest level of Education: _____

Religious Preference: Now: _____In childhood: _____

Single ☐ Living Together ☐ Married ☐ Partnered ☐ Engaged ☐ Separated ☐

Divorced ☐ Widowed ☐ If currently married, how many years:_____

Number of previous marriages: _____First names of previous mates, number of years together and number of children born to that relationship: _____

_____

How would you rate your parents' marriage? Very Happy ☐ Happy ☐ Avg ☐ Unhappy ☐
If your parents divorced, what was your age when this occurred? _____

Your Children: List name, age, sex, comments (custody, support, etc)

_____ _____

_____ _____

_____ _____

Your Present Health: Excellent ☐ Average ☐ Poor ☐ Date of last physical: _____

Are you presently on any medications? Yes ☐ No ☐ If yes, what kind and for what? _____

List previous psychotherapy, counseling, or personal/marital treatment. Also, list if you have ever been diagnosed with a mental health or substance abuse disorder: _____

Date: _____ Name of practitioner or agency: _____

How long did you attend counseling/psychotherapy services? _____

Have you ever been hospitalized for psychiatric care? Yes ☐ No ☐

If yes, when, where, for what? _____

Personal Health History:

Please check which of the following you have had:

CONDITION	Yes	Date	CONDITION	Yes	Date
Asthma			Paralysis		
Tuberculosis			Shaking		
Pneumonia			Impotence		
Meningitis			Miscarriage		
Bad headaches			Menstrual trouble		
High blood pressure			Nerve trouble		
Low blood pressure			Ulcer		
Diabetes			Discouragement		
Thyroid trouble			Worries		
Tumors			Depression		

CONDITION	Yes	Date	CONDITION	Yes	Date
Cancer			Tension		
Accident (serious)			Irritableness		
Sterility			Alcoholism		
Surgery (major)			Insomnia		
Fainting			Hysterectomy		
Convulsions			Appetite loss		
Hearing problems			Vasectomy		
Back trouble			Sexually unresponsive		
Heart trouble			Other		

Please put a check next to any symptoms that you have experienced in the last six months. Many people experience some of the symptoms below at certain times in their life; your honesty here will help the therapist know how to best treat you. Please fill out only one checklist per person.

____Depressed Mood
____Increased Anxiety
____Racing Thoughts
____Poor Concentration
____Sleeping Too Much
____Hearing Voices
____Change in Appetite
____Crying Spells
____Trouble Relating To Others
____Marital/Relationship Problems
____Nightmares
____Insomnia or Inability to Sleep
____Feeling Like Others Are Out to Get You
____Intentions of Hurting Yourself or Others
____Uncontrollable Sexual Urges
____Parent/Child Relationship Problems
____Feeling On Edge or Often Keyed Up
____Specific Fears or Phobias
____Obsessions or Compulsions
____Angry Outbursts
____Grief over Loss
____Thoughts of Hurting Self or Others
____Mood Swings
____Recent Weight Change
____Impulsive Behaviors
____Isolating From Others
____Difficulty with Memory
____Low Self-worth
____Feelings of Hopelessness
____Feelings of Guilt
____Feelings of Loneliness
____Abuse of Alcohol, Prescription Drugs or other Drugs
____Seeing or Hearing Things That Other People Do Not See or Hear
____Cutting/Burning on Arms, Legs, or Other Body Areas

Family History:

Mother's occupation: _____Her age: _____Age at death: _____Cause of death: _____

Father's occupation: _____His age: _____ Age at death: _____Cause of death: _____

Reason for seeking counseling?

What is the primary concern that you would like to discuss with the therapist? _____

_____

_____

What are your expectations of seeking counseling?

_____

_____ _____

Signature Date

CLIENT RIGHTS

You, your family, and your friends can be assured that the staff of Country Place Counseling, PLLC want to protect your rights We want to be sure that you receive all of your legal rights and that you are always treated with dignity and respect. Therefore, the purpose of the Client rights statement is to inform you of your rights and obligations to Country Place Counseling, PLLC as well as ours to you, in order to provide you the most effective treatment possible according to your needs.

1. You have the right to considerate and respectful treatment, regardless of age, race, sex, national origin, citizenship or legal status.
2. You have the right to expect our staff to send you or refer you to other places for treatment if we do not, or cannot, offer you the services you need.
3. You have the right to be treated as a person capable of managing your own affairs if you are eighteen (18) years of age or older, unless a court orders otherwise.
4. You have the right to be fully advised of and question the fees charged by Country Place Counseling, PLLC at the time of your intake process and throughout your services.
5. You have the right to know that your records are treated in a confidential manner and cannot be released without your consent, except under court order of law. Your records and private conversations with our staff will be kept in strict confidence, even after you stop coming here or services.
6. You have the right to get complete and current information concerning your treatment in terms which you can understand. You have the right to know the name, title, and professional qualifications of any person participation in your treatment.
7. You have the right to refuse treatment, except when limited by court order, law or rule and to be informed of the consequences of your refusal.
8. You have the right to a written Individual Treatment Plan, as well as the right to participate in the preparation of the plan. In addition, you have the right to participate in the review and any changes to be made.
9. Whenever we ask you (or your parent or guardian) to make a decision about something which affects you, you have the right to make your decision without force or pressure from us.
10. No one may take pictures of you or tape record in any program of Country Place Counseling, PLLC unless you agree in writing.
11. You have the right to speak up if you do not like your services, or if you think someone is taking away your rights.

YOUR RESPONSIBILITIES FOR CARE ARE:

1. To tell your counselor/therapist what you need.

2. To be on time for your appointments; call if you cannot keep your appointment.

3. To not endanger others with your behavior.

$. To follow the rules of conduct required in each program.

5. To not use nonprescription drugs (including alcohol) before or during your visit.

6. To cooperate to your fullest.

I have received a complete explanation in simple, non-technical language of my rights guaranteed to me as a client of Janet L. Douglas, LCSW at Country Place Counseling.

Client's Signature:_____ Date:_____

Staff Signature/Title:_____ Date:_____

Witness Signature:_____ Date:_____

CONSENT TO TREATMENT

Please read and sign. A "therapist-patient" or "treatment" relationship does not exist until after initial assessment is completed and we have decided to move ahead as evidenced by your signature on this form. It is important that we both agree that we are a good match in working together towards your goals. We will discuss this during the first visit and decide whether or not to proceed, and whether we need to continue the assessment for one or more subsequent visits. It is also important for you to be aware of the benefits and limitations of psychotherapy or other services you will be receiving. While it is generally expected that you will benefit from therapy, there may be periods of feeling worse before feeling better and there is no guarantee of success in therapy. There may be alternative treatments or modes therapy to consider. I encourage you to be come aware of these factors and to ask any questions you may have at any time during our work together.

CONFIDENTIALITY

State law protects the confidential nature of the therapist-patient relationship, but this protection is not absolute. I will not release clinical information to anyone unless given written permission to do so by the patient (or if the patient is a minor, by his or her parent or guardian). However, there are a few exceptions that allow or require the release of confidential information even in the absence of patient consent.

Examples Include:

1) The therapist must act appropriately when there is danger to the patient or to another person at the patient's hands. This generally means that the therapist may involve others when necessary to protect the patient if he or she is suicidal or is unable to provide self-care at a level necessary for basic survival, or to prevent harm to another person. State law also requires the reporting of abuse to or neglect of a child or an elderly or disables person when there is reason to believe it has occurred.

2) In response to a court order, the therapist must testify or release records. However, a therapist does not release records, depose or testify in response to a subpoena unless the patient or patient's guardian has given written authorization to do so or if the therapist is required by law to do so.

3) As professionals, we do consult with one another from time to time. Any clinical material is conveyed without identification whenever possible. At other times, it will be necessary (for example, if another therapist is covering calls during a vacation). Finally, case material is sometimes used in training, research, writing, etc. This is always done with identifying information removed and with great care and respect for your privacy. Any other release of information requires you or your guardian's written authorization.

OFFICE & FINANCIAL POLICIES

Fees: Payments are due at the time services are rendered; payment will be received at the beginning of each session. It is up to the discretion of the therapist to allow for a deferred payment.

Insurance: Claims will be filed for you, but you are responsible for the co-pay at the time of service.

Emergencies: I do not provide formal emergency services, yet I wish to be as available as much as is reasonably possible. You may call the office number at any time and leave a message if I do not answer. During the business day I can often, though not always, return calls fairly quickly. Nighttime and weekend calls will usually be returned the next business day. If you find yourself in an urgent situation, make a judgment about the prudence of waiting for my call

OFFICE & FINANCIAL POLICIES CONTINUED

versus calling 911 or going to the nearest emergency room for immediate care. If I am away for more than a day, my voice mail message will indicate that and state my expected date of return.

Death or Incapacity: In the event that the therapist dies or is otherwise incapable of providing for the clinical services of this office the patient consents for the therapist to designate Janice Feuerhelm, LPC as conservator for the records of this office, including all patient records, and at the time of death or incapacity of the therapist she will take possession of the patient records and make those available to the patient or a mental health professional of the patient's choosing at such time that a written request I made to this office.

Accounts: Payment may be made with cash or by check. I do 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. I do not depend on an outside collection service unless accounts are overdue by 90 days. I would much rather communicate with patients and find some solution to overdue accounts. Patient hereby consents 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 my bank. Statement, receipts or other documentation will not be issued to any delinquent account until paid in full.

Missed appointments: Unless waived by mutual agreement on a case-by-case basis, no-shows and cancellations will be charged for unless you cancel at least 24 hours in advance of the appointment time. **The fee for late cancellations (less than 24 hours notice) or no-shows is $50.** Patients arriving 15 minutes or more late to the appointment will be considered a no-show and must be rescheduled unless other arrangements are made with the therapist.

Credit Card Authorization for Late Cancellations and No-Shows: Authorization is given to charge credit/debit cards for late, no-show appointment fees and unpaid balance when incurred. Client understands the appointment policies of this office and assumes responsibility for payment of fees related to late cancellations, no-show appointments and unpaid balance. Such charges are payable immediately and will be automatically deducted, where applicable, and are not reimbursable by insurance.

☐Credit ☐Debit ☐Visa ☐Mastercard ☐Other_____

Name as it appears on card: _____

Billing Address:_____

16 Digit Credit/Debit Card #: _____

Expiration Date: _____ 3 Digit Security Code (found on back of card): _____

E-mail address: _____

Please sign below indicating that you have read, understand and agree to the information and terms as well as the policy of Country Place Counseling, PLLC for late cancellations, no-show fees and unpaid balances. The credit card information will be used for the purpose of collecting no-show and late cancellation fees as well as unpaid balance.

SIGNATURE_____**DATE**_____