Sylvia Clemons
Licensed Professional Counselor

Email: sylviaclemons@sbcglobal.net

Phone: 210-590-9800
Fax: 210-590-9166

Intake Information

Client Name_____ Date_____

Home Address_____ City_____ State_____ Zip_____

Mobile Phone: (_____)_____ Email _____

Workplace Name/Address_____

Sex: ____ M _____ F Age_____ Date of Birth _____

Marital Status: Single____ Divorced____ Married____ (1st___) (2nd___) (3rd___) Spouse's Name_____

Children (First Names & Ages)_____

How did you find out about this counseling service?_____

Complete this section only if client is a minor:

Responsible Party Name_____ Relationship to Client_____

Phones: Home (_____)_____ Work (_____)_____ Mobile (_____)_____

Home Address_____ City_____ State_____ Zip_____

Workplace Name/Address_____

Briefly describe the problem(s) you would like addressed in counseling _____

_____

_____

How long has this been a concern for you? _____

In what ways has this problem affected you? _____

_____

_____

What would you like to be different as a result of the counseling? _____

_____

Have you previously had any counseling? Yes_____ No_____

If yes, who did you see, when, and for how long? _____

_____

Name of personal physician _____Date of last check-up _____

Do you have any past or present physical/health-related issues? Yes____ No____

If yes, please describe: _____

_____

Please list any medications you are currently taking _____

_____

Have you ever used alcohol, drugs, or nicotine? Yes____ No____

Do you use any of them at present? Yes____ No____

If yes, please describe: _____

Did (or does) your use of alcohol, drugs, or nicotine cause problems in your life? Yes_____ No_____

If yes, please briefly describe: _____

_____

Is there any history of alcohol or drug problems in your family? Yes_____ No_____

If yes, please briefly describe: _____

_____

Are you presently involved with the legal and/or criminal justice system? Yes____ No____

If yes, please describe: _____

_____

What is the highest grade or degree that you completed in school? _____

If less than 12th grade, do you have your G.E.D.? Yes____ No____

Do you currently attend church? Yes_____ No_____

If yes: Where do you attend? _____ How long have you been attending there? _____

How often do you attend services? _____

Pastor's name _____ Does he know you are seeking counseling? Yes____ No____

Have you consulted with your pastor on the problem(s) for which you are seeking counseling? Yes____ No____

If no: What are your reasons for not currently attending and being active in a church? _____

_____

Before signing below, please read the General Office Policy Information sheet.

I (client/responsible party) have read and understood the handout, General Information About Office Policies, furnished to me and agree to the following:

- **Private Pay Clients:** I agree to be responsible for payment of the $50.00 "no show/late cancellation" fee for any appointments made but not kept or cancelled 24 hours in advance for non-emergency reasons.
- **Insurance Clients:** I agree to be personally responsible for payment of the $50.00 "no show/late cancellation" fee if I fail to cancel or keep an appointment because I understand my insurance company cannot be billed for missed appointments. I further understand that I am expected to pay for such sessions and hereby agree to do so.

Signature _____ Date _____

Intake Checklist

Name_____ Date_____

Please check all that apply:

Now	Past		Now	Past	
____	____	Depression	____	____	Low energy
____	____	Low self-esteem	____	____	Poor concentration
____	____	Hopelessness	____	____	Worthlessness
____	____	Guilt	____	____	Sleep disturbance (more/less)
____	____	Appetite disturbance (more/less)	____	____	Thoughts of hurting yourself
____	____	Isolation/social withdrawal	____	____	Thoughts of hurting someone else
____	____	Sadness/loss	____	____	Stress
____	____	Anxiety/panic	____	____	Heart pounding/racing
____	____	Chest pain	____	____	Trembling/shaking
____	____	Sweating	____	____	Chills/hot flashes
____	____	Tingling/numbness	____	____	Fear of dying
____	____	Fear of going crazy	____	____	Nausea
____	____	Phobias	____	____	Obsessions/compulsive behaviors
____	____	Thoughts racing	____	____	Can't hold on to an idea
____	____	Easily agitated	____	____	Can't get my mind to turn off
____	____	Delusions/hallucinations	____	____	Not thinking clearly/confusion
____	____	Feeling that you are not real	____	____	Feeling that things around you are not real
____	____	Lose track of time	____	____	Unpleasant thoughts that won't go away
____	____	Anger/frustration	____	____	Easily annoyed/agitated
____	____	Defies rules	____	____	Blames others
____	____	Argues	____	____	Problems due to drug &/or alcohol use
____	____	Blackouts	____	____	Excessive use of prescription medications
____	____	Physical abuse issues	____	____	Legal problems due to alcohol/drug use
____	____	Spousal abuse issues	____	____	Excessive behaviors (spending/gambling)
____	____	Sexual abuse issues	____	____	Other problems/symptoms:
____	____	Relationship problems	____	____	_____
____	____	Family problems	____	____	_____
____	____	Marital problems	____	____	_____
____	____	Work-related problems	____	____	_____
____	____	Problems with children	____	____	_____
____	____	Problems with grandchildren	____	____	_____
____	____	Tired all the time	____	____	_____

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General Information About Office Policies

APPOINTMENTS:

1. Counseling appointments are generally scheduled to last 50 minutes each time and are usually scheduled on a once-a-week basis, unless other arrangements are made.
2. If you have scheduled an appointment and need to change it or cannot keep it, please contact my office phone at least 24 hours in advance. Since that hour has been reserved especially for you and is not available to others who might also need it, you will be charged a $50.00 "no show/late cancellation" fee for appointments that are not canceled 24 hours in advance or are not kept at all.
3. If you have had a personal emergency situation and cannot give 24 hours notice, please contact me at the earliest possible time to cancel or reschedule, indicating the nature of the emergency. You will not be charged for the session in the case of a true emergency.
4. If you are late for an appointment, the session will still end at the scheduled time, and you will be charged for a full session. If I am late for an appointment, you will be charged for only a partial session or the time will be extended to allow for a full session.

PAYMENT FOR SERVICES:

MILITARYONESOURCE/EAP REFERRALS:

1. No payment is required at the time of service & will be handled directly through your referral source.
2. The charge for "no show/late cancellation" appointments does not apply. However, I do request your consideration in letting me know as soon as possible if you are unable to keep an appointment.

PRIVATE PAY/INSURANCE:

1. All payment for services are to be made at the time of the appointment unless other arrangements are made. Payment can be made in cash, check or credit card. If a check is returned as insufficient, you will be charged the bank fee, in addition to the amount of the check and will be billed for the amount due.
2. If you cannot afford the full fee of $100.00 per session, you may ask to be considered for a sliding scale fee which is based on your total, gross, annual household income.
3. If you have insurance that covers outpatient mental health services, it may pay for 50% to 80% of the cost of counseling after any deductible that may apply.
   - **IN-NETWORK:** If I am in-network with your insurance company, you will be responsible for deductible and/or co-pay only as designated by your particular policy and I will file with your insurance.
   - **OUT-OF-NETWORK:** If I am out-of-network with your insurance company, you will be given the necessary information to file for reimbursement if you choose to do so. You will be asked to pay in full at the time of each session and any insurance reimbursements would be paid directly to you.

EMERGENCIES:

In cases of emergency, please contact me at 210-590-9800. If I am not immediately available, please leave a message and number where you can be reached, specifying that it is an emergency. You will be contacted as soon as possible. If you cannot reach me at the moment you call and believe you must have immediate attention, please call 911 or go to the nearest hospital emergency room.

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Records and Confidentiality:

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your/client's privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This form is an agreement between you, the client, and this counselor. The word "you," when used below, refers to your child, relative, or you as a client.

When I do an evaluation, diagnose, treat or refer you, I will be collecting what the laws call Protected Health Information (PHI) about you. I need to use this information to decide on what treatment is best for you and to provide counseling for you. I may also share your information with others who provide treatment to you. But that information will be shared only as requested and with a signed Consent for Release of Information from you.

All our communication becomes part of the clinical record, which is accessible to you upon request. Please be aware that I may choose not to release these records if they could be emotionally or legally damaging to the client. I will make these records available to another mental or medical health professional at the client's request. In the case of a minor, request may be made by a parent or legal guardian only.

I will keep confidential anything you say to me, with the following required exceptions:

(a) you reveal to me any incidence of child or elder abuse
(b) I determine that you are a danger to yourself or others
(c) I am ordered by a court of law to disclose information
(d) I am required to use the data to defend myself in a complaint, lawsuit or claim.

By signing this form, you are agreeing to let me use your information here and send it to others, such as insurance companies or other providers that I might need to refer you to. You have the right to ask me in writing not to use or share your information. Although I will try to respect your wishes, I am not required to agree to these limitations. There is a vulnerable aspect in electronic communication such as faxes, emails, cell phone texts/calls, etc. that may not be preventable regardless of all safeguards.

Counseling of Minors:

I am committed to providing confidentiality for minor clients to provide the most therapeutic experience. However, I will provide generalized information about the therapy sessions to the parents/guardians of the client, as I feel necessary and helpful. Parents of minors in therapy are involved in the process and will participate in formulating and carrying out treatment goals.

Records and Confidentiality...continued

Consent for treatment of minors must be signed by the parent or guardian with the legal authority to do so and all fees must be paid by the consenting parent regardless of your legal agreement.

In the case of divorced parents, please provide a copy of custody agreement within one week of the first counseling session. Receipts are provided for you at each session if you are needing to seek reimbursement from the other parent. However, I will not intervene in any dispute of financial responsibility between the consenting parent and another party.

Agreement:

By signing below, I consent to treatment with Sylvia Clemons, LPC, LCDC. I acknowledge that I have read and understand the informed consent and the HIPAA Notice of Privacy Practices, and that any questions I had have been answered to my satisfaction.

_____ Date _____

Client's Signature or Minor's Parent/Guardian Signature

_____ Date _____

Counselor's Signature

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Name:_____
First Middle Last

Employer: _____ ☐ Full time ☐ Part Time

INSURANCE INFORMATION

Please provide a photocopy of insurance card(s), front & back.

Primary Insurance Carrier: _____ Phone # (Mental Health) (_____)_____

Company Claims Address _____
Street/Box City State Zip

Policy Holder: Name: _____ Date of Birth: _____

Address: _____ ☐ Male ☐ Female

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

I.D.#_____ Group #_____

Relationship of Client to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Secondary Insurance Carrier: _____ Phone # (Mental Health) (_____)_____

Company Claims Address _____
Street/Box City State Zip

Policy Holder: Name: _____ Date of Birth: _____

Address: _____ ☐ Male ☐ Female

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

I.D.#_____ Group #_____

Relationship of Client to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

RESPONSIBLE PARTY INFORMATION

Person Responsible for Payment (if other than patient):

Name: _____ Check if: ☐ Custodial Parent ☐ Legal Guardian

Address: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Relationship to Patient: _____ E-mail: _____

PLEASE READ BELOW BEFORE SIGNING:

- I, as the patient/responsible party, authorize Sylvia Clemons, LPC, LCDC, to release information acquired in the course of evaluation or treatment to my insurance carrier(s) or its representative(s) only as is necessary and appropriate for payment of services.
- I assign to her all payments for services rendered. I understand that this is a direct assignment of my rights and benefits under this insurance policy. If my current policy prohibits direct payment to the health provider, then I hereby instruct and direct my insurance company to make benefit checks payable to me and mail them to me c/o Sylvia Clemons, LPC, LCDC, at the address provided.
- I understand that I am responsible for my deductible, my co-pay, and any other charges not covered by insurance, as well as any appointments not cancelled and not kept as scheduled.

Signature _____ Date _____