Ennis Counseling Center
219 W. Brown St.
Ennis, TX 75119

Erin Jackson, MS, LPC

Phone (817) 219-4189
Fax (972) 875-3808
www.enniscounseling.com

WELCOME

Welcome to Ennis Counseling Center. In order to serve you better we request that you take a few moments to fill out the following information:

PATIENT REGISTRATION

Date: _____

Patient: _____
Last First Middle Initial

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____
Please initial if we may call or text you at these numbers: _____Primary _____Secondary

Male Female Date of Birth: _____ Age: _____

Status: Single Married Divorced Widowed

Employed by: _____ Email address: _____
Please initial if we may email you at this address: _____ email

Spouse Name

_____
Last First Middle Initial

Male Female Date of Birth: _____

Children's names, genders, ages

_____
_____

Religious Preference: _____ **Church member:** _____

Person financially responsible: _____
Last First

Address: _____
Street City State

In case of emergency notify: _____

Relationship: _____ Phone: _____

Referred by: _____

How would you rate your current health? _____

Are you currently on any medications? _____ Yes _____ No

Medication	Dosage	Physician	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What concerns have brought you to counseling? _____
_____
_____

Where are your concerns causing the most problems for you?

Circle all that Apply: School Work Home Marriage God Relationships w/others Substance Abuse Mental Health Other: _____

What concerns have been identified by others? _____
_____
_____

Have you been in counseling before? _____Yes _____No

If so, indicate the following. Please use the back of paper if needed:

1. Who was the counselor? _____
2. What was the problem? _____
   _____
   _____
3. What were the results? _____
   _____

Please rate the severity of your present concerns on the following scale:

Mild Moderate Severe Totally Incapacitating

ADDENDUM TO PATIENT REGISTRATION

(Complete when Child is Client)

Parent Information:

1) Biological Father's Name: _____

   DOB: _____ SS #: _____

   Address: _____ Apt. #: _____

   City: _____ State: _____ Zip Code: _____

   Hm Phone: _____ Cell Ph.: _____

   Place of Employment: _____ Bus Ph.: _____

   Step-mother's Name: _____

2) Biological Mother's Name: _____

   DOB: _____ SS #: _____

   Address: _____ Apt. #: _____

   City: _____ State: _____ Zip Code: _____

   Hm Phone: _____ Cell Ph.: _____

   Place of Employment: _____ Bus Ph.: _____

   Step-father's Name: _____

3) Siblings Names and ages: _____
   _____
   _____

Consent for Counseling Minors

(Complete when child is client)

Child's Name: _____

Date of Birth: _____

This is to certify that I give permission to Erin Jackson, MS., LPC and Ennis Counseling Center for treatment of my child.

This counseling may include individual or family psychotherapy, counseling, and testing. This counseling may include consultation with other associates.

This counseling may also include referrals to other appropriate State and County or professional agencies for further counseling.

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian

_____

Street Address

_____

City/State/Zip

_____

Phone

_____

Witness/Title

I. Philosophy and Purpose Statement

Erin Jackson, M.S. is a Licensed Professional Counselor. I earned a Bachelor of Science in Child Development at Texas Woman's University and a Master's of Science in Counseling at Texas A&M Commerce. The counseling approach I take is Person Centered Therapy which means you will take an active role in your treatment. I will work in collaboration with you in order to determine realistic and workable goals for therapy that will meet your needs. The counseling relationship should have an atmosphere of respect and cooperation in order to establish growth and change. It is agreed that the client shall make a good faith effort at personal growth and engage in the counseling process as an important priority at this time in their life. I agree to utilize all appropriate skills and research efforts to aid the client in achieving specific goals. While it is impossible to guarantee any specific results from our time together, we will work together to achieve the best results possible. The client understands and consents to work with the therapist noted herein and accept the benefits and limitations of her license status.

II. Confidentiality Policy

The time we spend together is confidential and private. I will keep everything we discuss confidential except as required by law. The law requires confidentiality and privileged communication to all clients with the following exceptions: 1) the client signs a written release of information indicating informed consent to such release; 2) the client expresses serious intent to harm himself/herself or someone else; 3) there is evidence or reasonable suspicion of abuse against a minor child, elder person 65 yrs or older or dependent adult; 4) a subpoena or other court order is received directing the disclosure of information; 5) for consultation purposes; or 6) If you choose to contact me via email or text, I cannot guarantee confidentiality as we do not offer encryption. To guarantee confidentiality, please limit communication through phone calls. I will contact the nearest of kin and/or the proper authorities if, in my opinion, a person is deemed to be a threat to him/herself or others. As a Licensed Professional Counselor I am required by law to report incidences of physical or sexual abuse of a minor or of the elderly. Children over the age of sixteen are considered legal adults when involved in mental health services. Confidentiality in these situations is restricted by the same laws that apply to adults. Before the age of sixteen, communication of confidential information between counselor, client, and parents or legal guardians is at the discretion of the counselor. Clients with any concerns or questions about this policy agree to raise them with their counselor at the earliest possible time to resolve them in the client's best interest.

III. Referral Policy

If at any time during the counseling process you feel uncomfortable and would like me to refer you, please let me know. This is a professional relationship and the emphasis is to help you. Suspension, termination or referral shall be discussed between counselor and client for a pattern of behavior that suggests a lack of commitment to counseling or for any unresolved conflict or impasse between counselor and client. If in the event of an emergency you are unable to contact me, these options are always available: Suicide and Crisis Center of Dallas (214) 828-1000, 24 Hour Mental Health Crisis Line (866) 260-8000, or call (911).

IV. Financial Agreement

The fee for each session is due at the beginning of the hour. Cash, personal checks, or credit cards may be used. We agree to and ask that clients maintain responsible relations regarding appointment times. Any appointment canceled within 24 hours of the appointment time or that is missed without justification will be charged to the client.

FEE DISCLOSURE ACKNOWLEDGEMENT

- Sessions are 45 minutes in duration
- $125.00 for Initial Intake
- $ 95.00 for individual sessions/marriage counseling
- $ 45.00 for group therapy
- $ 95.00 Family with Client
- $ 95.00 Family without Client
- $150.00 for Sessions conducted outside of the office, such as hospital visits or interventions

The following is a listing of fees for services requested in addition to your regular sessions (these fees may not be covered by your insurance plan)

- $ 95.00 Therapist's time in preparation of records & special correspondence
- $ 25.00 Returned checks (NSF)
- $ 15.00 GADS test
- $ 10.00 ADD/ADHD testing
- $ 25.00 Copy of records, first 20 pages, $0.50 per page thereafter (30 days to respond)
- $200 per hour for court and legal services and requires a separate contract

V. Service Agreement

We, the undersigned therapist and client have read and fully understand this agreement and stated policies. We agree to honor these policies and will respect one another's views and differences. Finally, we agree that any disputes or modification of agreement shall be negotiated directly between the parties; if these negotiations are not satisfactory, then the parties agree to mediate any differences with a mutually acceptable third-party mediator.

Client Signature _____ Date_____

Counselor Signature_____ Date_____

INSURANCE INFORMATION FORM

Primary Coverage: Insurance Company Name_____

Patient Name: _____
Subscriber Name: _____
Subscriber: Sex: M _____ F _____ Birthdate: _____ SSN: _____
Patient/Subscriber Relationship: _____ Employer: _____
Effective Date: _____ Group #: _____
Insurance ID#: _____
Insurance Phone#: _____

Authorization to Release Information: I hereby authorize Erin Jackson, MS., LPC to release medical information and necessary data pertinent to the filing of insurance papers in the interest of the patient named above and the facility.

Assignment of Benefits: I authorize my insurance carriers to pay benefits directly to Erin Jackson, MS., LPC on my unpaid services filed on my behalf by Erin Jackson, MS., LPC.

Responsibility for Payment: I understand that I am responsible for payment to Erin Jackson, MS., LPC for charges for the above patient regardless of my insurance company. I also understand that Erin Jackson, MS., LPC is not ultimately responsible for collecting my insurance or negotiating settlements of claims. Erin Jackson, MS., LPC will bill the primary insurance company for the plans in which she participates. If she does not receive payment in full within 90 days, the balance will be automatically billed to you for payment.

Possible Additional Fees: I understand there is a charge of $95.00 for missed appointment without 24-hour notice. There are also additional fees for any legal services. You have the primary responsibility to know what is covered by your individual plan. Your insurance company may not cover all services. Erin Jackson, MS., LPC will try to inform you of such services; however, you are responsible for services that are not covered by your insurance company. My relationship is with you and not your insurance company. I cannot keep track of the ever-changing rules of hundreds of plans.

Signature of Patient/Insured: _____

Date: _____

Please complete this page ONLY if you intend to use a credit / debit card for fee payment(s)

For Your Convenience, I gladly accept Visa, MasterCard, Discover, Personal Checks or Cash. If writing a personal check or using a money order, please pay to the order of: **Erin Jackson, MS., LPC**

CREDIT CARD PREAUTHORIZATION

I, authorize **Erin Jackson, MS., LPC** to keep my signature on file and to charge fees, or partial fees as applicable, to my credit card account for services rendered

to:_____as of _____/_____/_____

(Client Name: Please Print) **Date**

I understand that this authorization is valid until canceled in writing. I understand that charges for ongoing professional services to include telephone calls that exceed 10 minutes or for cancellations without 24 hour prior notice will normally be posted to my credit card account within a week of each service / appointment date. It is my practice policy to charge for missed appointments without appropriate notice as outlined in the signed Informed Consent Service Agreement and for professional calls that exceed 10 minutes. Please help me to serve you better by keeping scheduled appointments.

I agree that if I have any problems or questions regarding charges to my account, I will contact Dana R. Collins for assistance. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Erin Jackson, MS., LPC and those attempts have failed.

ADDITIONALLY, I HEREBY CERTIFY THAT I AM AUTHORIZED / APPROVED TO USE THIS CARD FOR THE PURPOSES OF PAYING FOR COUNSELING SERVICES RENDERED, CANCELLED APPOINTMENTS WITHOUT PRIOR NOTICE, AND ANY OTHER PREVIOUSLY AGREED UPON PROFESSIONAL FEES OUTLINED IN THE INFORMED CONSENT SERVICE AGREEMENT.

Cardholder Name (Please Print):

_____

Billing Address (where billing statements are mailed):

_____

_____

Cardholder's Phone Number: ☐ Cell Phone ☐ Home Phone **Number & Area Code:**_____

Card Type (Circle) **Visa** **MasterCard** **Debit / CheckCard** **Credit**

Acct No: _____EXP. Date:_____digit V-Code: _____

The V-Code is a 3 or 4 digit number on the back of your card by your signature, usually after the account number

CARDHOLDER /Signature:_____ **Date:**_____/_____/_____

DRIVER'S LICENSE # _____ **State Issued:**_____

Client's Signature: **Date:**

NOTICE OF PRIVACY PRACTICES
FOR PERSONAL HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Summary

This notice describes how your personal health information (PHI) is protected, and how we may use and disclose this information. PHI includes personally identifiable information that relates to our past, present and future health treatment or payment for health care services. Our employees and professional staff are requir4ed to comply with this privacy policy, and have access to this information only when there is an appropriate reason to do so, such as to confer with other health care providers or to submit claims for these services. Under the Health Insurance Portability and Accountability Act (HIPAA) you are afforded privacy rights regarding the use and disclosure of your health information. These include:

- A right to be informed of the potential uses and disclosures of your protected health information, and to limit those uses and disclosures of this protected health information;
- A right to receive this written notice that explains how we may use and disclose your protected health information, your rights under HIPPA's privacy rule as a covered entity under HIPPA.
- A right to a paper copy of this notice, or to have your legally designated representative receive a copy of this notice; you are asked to acknowledge receipt of this notice.
- A right to amend your record, to restrict what information from your record is disclosed to others, and to receive an accounting of disclosures of this information that were made without your authorization other than for treatment, payment or health care operations.
- A right to have your complaints about my policies and procedures recorded in these records.

As a health care provider, I am making a good faith effort to see that you and/or your representative have received and acknowledge this notice of privacy practices. If you are seen for emergency treatment, you will receive this notice as soon as practically possible afterward.

Disclosure for Treatment, Payment and Health Care Operations

I may use or disclose your protected health information for certain treatment, payment, and health care operations purposes without your authorization. To help clarify these terms here are some definitions:

- PHI refers to information in your health record that can identify you.
- Treatment is when I or another healthcare provider diagnose or treat you. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist, regarding your treatment.
- Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Health Care Operations is when I disclose your PHI to your health care service plan or to your other health care providers contracting with your plan, for administering the plan, such as case management or care coordination.
- Use applies only to activities within ENNIS COUNSELING CENTER, such as sharing, employing, applying utilizing, examining and analyzing information that identifies you.
- Disclosure applies to activities outside of my office, such as releasing, transferring, or providing access to information.

Please initial each paragraph and sign at the bottom for understanding of each policy.

_____Acknowledgement of receipt of Notice of Privacy Practices

_____Missed Appointment Policy

We agree to and ask that clients maintain responsible relations regarding appointment times. Any appointment canceled within 24 hours of the appointment time or that is missed without justification will be considered a "no show." Charges for "no shows" are $95.00 to be paid in full before scheduling next appointment.

_____ Disclaimer

Dana R. Collins counseling services, LLC and Erin D. Jackson, LPC are separate entities sharing the assumed name "Ennis Counseling Center." Therefore, each entity is only liable for services offered or provided by the respective entity. The entities shall not be held jointly liable for services offered or provided solely by one entity or the other. By signing this form, you acknowledge that you have read this disclaimer and agree to the terms contained herein.

Counselor I am seeing:

☐ Dana R. Collins, MA, LPC-S ☐ Erin Jackson, MS, LPC, NCC

☐ Derrick Williams, LPC-Intern
Supervised by Dana R. Collins, MA, LPC-S

☐Molly Barlow, Practicum Student
Supervised by Dana R. Collins, MA, LPC-S

_____Text/Email Policy

Please initial if it is okay to text or email you at the phone number and email that you have provided. Understand that if you choose to contact me via email or text, I cannot guarantee confidentiality as we do not offer encryption. To guarantee confidentiality, please limit communication through phone calls.

Please sign and date this acknowledgement form. This form will become a part of your permanent medical record. Thank you.

Signature Date

RELEASE OF INFORMATION

Date: _____

I hereby authorize Erin Jackson, MS., LPC to release confidential information from my counseling records.

Name of Patient: _____ DOB: _____

Date of Intake: _____ SS#: _____

The above information is released for the following purpose (circle all that apply):

- Coordination of care
- Legal services
- Child Custody
- Other _____

I understand that only such confidential information concerning the above person will be released as is considered essential to the purpose stated above. All information released by sending organization or person shall be held as confidential by the receiving organization or person.

INFORMATION TO BE RELEASED TO: _____

_____

I understand that the Ennis Counseling Center, its employees, and therapists are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Patient Signature: _____

Expiration of Authorization: _____

Parent of Legal Guardian: _____

Witness: _____

Global Assessment

Please rate the following symptoms from 0 to 10:
0 = Not at all
1 to 3 = Mild
4 to 6 = Moderate
7 to 9 = Severe
10 = Totally Incapacitating

_____ Depression

_____ Anxiety

_____ Worry

_____ Stress

_____ Physical Pain

_____ Anger

_____ Mania (increased energy, talking a lot, decreased need for sleep)

_____ Hallucinations (hearing or seeing things that others do not)

_____ Delusions (ideas that others think are strange)

_____ Obsessive thoughts

_____ Compulsive behaviors

_____ Poor Concentration/Memory

_____ Change in Appetite

_____ Decreased energy

_____ Decreased motivation

_____ Hyperactivity

_____ Suicidal ideas

_____ Homicidal ideas

_____ Insomnia