

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: _____

Client Name: _____

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 Substance Abuse Work Abuse Home Mental Health Marriage Other: _____ God Relationships w/others

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:

- Who was the counselor? _____
- What was the problem? _____

- 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: _____

Client Name: _____

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

- \$150.00 for Initial Intake
- \$100.00 for individual sessions/marriage counseling – 45 minutes
- \$125.00 for individual sessions/marriage/family – 60 minutes
- \$ 50.00 for group therapy
- \$100.00 Family with Client
- \$100.00 Family without Client
- \$200.00 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)

- \$100.00 Therapist's time in preparation of records & special correspondence
- \$ 30.00 Returned checks (NSF)
- \$ 25.00 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

If you are using insurance, we will provide you an estimate of cost for your sessions provided by your specific insurance plan.

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 required 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, MA, LPC, Collins Services & Management, LLC, and Erin D. Jackson, MS, LPC, NCC, 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, MA, LPC-Associate
Supervised by Dana R. Collins, MA, LPC-S
- Kristen S. Pike, MEd, LPC-Associate
Supervised by Dana R. Collins, MA, LPC-S
- Molly Barlow, MA, LPC-Associate
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

Client Name: _____

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

Informed Consent to Telehealth

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Client Name: _____

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

I understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures, could be interrupted or could be accessed by unauthorized persons, and are not guaranteed to be confidential as I do not offer encryption. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications by providing written notification. My signature below indicates that I have read this Agreement and agree to its terms.

Client (or Guardian) Signature

Date

Counselor Signature

Date

Guidelines, Waiver and Release of Liability

With community transmission of communicable diseases, you could be exposed to infectious diseases including, but not limited to COVID-19 (also called Coronavirus). Our office is following State and Federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of communicable diseases. However, it is possible that these precautions will not always be successful in blocking the transmission of these diseases.

By presenting yourself or your child for counseling services, you assume and accept the risk that you or your child may inadvertently be exposed to a communicable disease.

In order to see clients as safely as possible in person, Ennis Counseling Center is asking each client and family member to adhere to the following guidelines:

- Maintain social distancing
- Use hand sanitizer or wash your hands using the 20 second method outlined by the CDC when entering the building, after restroom breaks, and prior to leaving.

If you have been exposed to a communicable disease prior to your counseling appointment, you may spread the disease to the counselor, counseling staff, and to other clients in the practice. Therefore, prior to each appointment, we require you to answer the following questions:

Have you, your child, or others accompanying you to today's appointment been tested positive for or been diagnosed as having COVID-19?

Yes _____ No _____

If so, when? Date _____

Do you, your child, or others accompanying you to today's appointment have:

- | | | | |
|--|--------------------|-----------|----------|
| • A fever? | Today's temp _____ | Yes _____ | No _____ |
| • A cough? | | Yes _____ | No _____ |
| • Shortness of breath and/or trouble breathing? | | Yes _____ | No _____ |
| • Persistent pain, pressure or tightness in the chest? | | Yes _____ | No _____ |

If any of you have any of these symptoms or have recently tested positive for or been diagnosed with COVID-19, you will be asked to reschedule your counseling appointment.

- I acknowledge and accept the risk of exposure in our counseling office to a communicable disease, included but not limited to COVID-19, and consent for treatment.

I knowingly and freely assume all risks, both known and unknown, relating to my and/or my child's visit to Ennis Counseling Center. I hereby release, waive, relinquish, and discharge Ennis Counseling Center, along with their employees, volunteers, or other representatives from any and all claims, demands, liabilities, rights, damages, expenses, and causes of action of whatever kind or nature, and other losses of any kind, whether known or unknown, foreseen or unforeseen as a result of my visit to Ennis Counseling Center.

Client or Parent's Signature

Date