Janice Feuerhelm, LPC
1324 NW John Jones Dr, Burleson, TX 76028
Telephone: 817-946-5858

MINOR

Client - Personal Information

Child's Name:_____ Date of Birth: _____Age: _____

SSN: _____

Street Address:_____ City_____/State:____ Zip Code:_____

Sex: □ Female □ Male Religious Affiliation (if any):_____

Home Phone_____ Is it okay to leave a message? Yes No

Cell Phone_____ Is it okay to leave a message? Yes No

In an emergency, who do we call? Contact Name: _____

Contact Phone:_____

With whom does Child live: □ Both Parents □ Mother Only □ Father Only □Shared Custody

Child's School: _____Grade Level:_____

Primary Physician: _____Primary Physician Phone: _____

Parent/Guardian Information

Parent/Guardian's Name: _____Date of Birth: _____ SSN: _____

Street Address: _____City/State:_____ Zip Code:_____

Sex: □ Female □ Male Relationship to Client:

Religious Affiliation (if any):_____

Home Phone_____ Is it okay to leave a message? Yes No

Cell Phone_____ Is it okay to leave a message? Yes No

What is your current relationship status: □ Single □ Never Married Single □ Divorced Single
□ Widowed □ Engaged □ Living Together □ Same-Sex Partners □ Married □ Separated

Employer: _____ Occupation:_____

Who referred you to this office? _____

Insurance Information

1st Insurance: _____ Phone: _____

Claims address: _____

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 Janice Feuerhelm, LPC of the Counseling and Wellness Center. 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:** _____

Household Information

Do you have any pets in the home? _____ If so, what type? _____

List any other individuals living in your home: _____

_____

_____

Medical and Mental Health History / Information

Is the child currently being treated by a physician for any medical conditions? If so, please describe:

_____

_____

Is the child currently taking medication? No Yes; Medication name/dose

_____

Has the child ever seen a Psychiatrist or any other mental health provider? □No □ Yes;
If yes, when? _____

Focus of treatment: _____
Helpful? □ Yes □ No

Symptom Checklist

Please put a check next to any symptoms that you or your minor child has experiences in the last six months. Many people experience some of the symptoms below at certain times in their life; your honestly here will help the therapist know how to best treat you. Please fill out only one checklist per person. Please ask therapist if you need additional lists.

____Depressed Mood
____Increased Anxiety
____Racing Thoughts
____Inability to Concentrate
____Sleeping Too Much
____Hearing Voices
____Change in Appetite
____Crying Spells
____Feelings of Guilt
____Mood Swings
____Recent Weight Change
____Nightmares
____Isolating From Others
____Difficulty with Memory
____Feelings of Hopelessness
____Trouble making Friends
____Troubled Academic Performance
____Cruelty to Animals or Other Children
____Defiant or Oppositional Toward Adults
____Angry Outbursts
____Fear of Going to School
____Impulsive Behaviors
____Insomnia or Inability to Sleep
____Feeling Like Others Are Out To Get You
____Thoughts of Hurting Yourself or Others
____Low Self-esteem
____Parent/Child Relationship Problems
____Feeling On Edge or Often Keyed Up
____Specific Fears or Phobias
____Obsessions or Compulsions
____Trouble Relating To Others
____Feelings of Loneliness
____Grief over Loss
____Trouble Carrying Out Responsibilities
____Intentions of Hurting Self or Others
____Abuse of Alcohol, Prescriptions Drugs, or Other Drugs
____Lying
____Stealing
____Restless/Inability to Stay Still
____Often Feels Nervous or Stressed Out
____Fears Separation from Mom or Dad
____Frequent Physical Complaints
____Cutting/Burning on Arms, Legs, or Other Body Areas
____Seeing or Hearing Things That Other People Do Not See or Hear

_____

Above section prepared by: Relationship to Child:

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

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 Janet Douglas, LCSW 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 or no-show appointment fees when incurred. Patient understands the appointment policies of this office and assumes responsibility for payment of fees related to late cancellations or no-show appointments. 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: _____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 Janice Feuerhelm, LPC for late cancellations, no-show fees and remaining balance. The credit card information will be used for the purpose of collecting no-show, late cancellation fees and remaining balance.

SIGNATURE_____**DATE**_____

CLIENT RIGHTS

You, your family, and your friends can be assured that the staff of Janice Feuerhelm, LPC want to protect your rights We can 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 Janice Feuerhelm, LPC, 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 Janice Feuerhelm, LPC 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 Janice Feuerhelm, LPC 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 Janice Feuerhelm, LPC.

Client's Signature:_____ Date:_____

Staff Signature/Title:_____ Date:_____
And /or
Witness Signature:_____ Date:_____