Rev. 01/2020

Janice Feuerhelm, LPC

1324 NW John Jones, Burleson, TX 76028

Telephone: 817-946-5858

CLIENT INFORMATION

Patient Name: _____

Race:_____ Sex:_____ DOB:_____

Address: _____ City/State/Zip: _____

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

Home or Work Phone: _____ Okay to leave message at this number? YES NO

Email: _____ Okay to leave message through email? YES NO

Would you like to be on the Counseling & Wellness Distribution list for emails about specials, events, promotions, newsletters? Y or N

Emergency Contact: _____ Cell/Home:_____

PCP:_____ Phone:_____

Who referred you to this office? _____

Insurance:_____ Phone:_____

Claims address: _____

Policy Holder:_____ DOB:_____ Sex:_____

ID#:_____ GRP#:_____

Policy Holder's Address: _____

Policy Holder's Phone Number: _____ Employer:_____

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. 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:_____

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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: _____

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? _____

_____

Any other information that could help the therapist not otherwise included here? _____

_____

_____

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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		
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 experiences 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

____Insomnia or Inability to Sleep

____Feeling Like Others Are Out to Get You

____Thoughts of Hurting Yourself or Others

____Uncontrollable Sexual Urges

____Parent/Child Relationship Problems

____Feeling On Edge or Often Keyed Up

____Change in Appetite
____Crying Spells
____Feelings of Guilt
____Mood Swings
____Recent Weight Change
____Impulsive Behaviors
____Isolating From Others
____Difficulty with Memory
____Low Self-worth
____Feelings of Hopelessness
____Angry Outbursts
____Specific Fears or Phobias
____Obsessions or Compulsions
____Trouble Relating To Others
____Feelings of Loneliness
____Seeing or Hearing Things That Other People Do Not See or Hear
____Marital/Relationship Problems
____Intentions of Hurting Self or Others
____Abuse of Alcohol, Prescriptions Drugs, or other Drugs
____Cutting/Burning on Arms, Legs, or Other Body Areas
____Nightmares
____Grief over Loss

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 primary goals for counseling? What do you want to achieve with the help of counseling?_____

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 become 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 disabled 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. Fees are determined by Insurance Provider Plan. Cash Rate Fee is $100.00 per individual and $120.00 per couple. **There will be a 2.9% convenience fee added for credit card payments. I will accept cash or checks with no added fees.**

Insurance: In-Network Claims will be filed for you, but you are responsible for the co-pay at the time of service. You will also be responsible for any unpaid balances from insurance.

E-mail and Text Messages: The undersigned therapist uses and responds to e-mail and text messages only to arrange or modify appointments. Please do not send e-mails related to your treatment or therapy sessions as electronic communications are not completely secure and confidential. Any therapy related questions or issues will not be addressed by the therapist in any electronic communication but will be dealt with during your next therapy session. Any electronic transmissions of information by you are retained in the records of your therapist. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. You should know that any e-mails or texts received from you and any response sent will become part of your therapy record.

Social Media: Your therapist does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the therapist and the client. It can blur the boundaries of the professional relationship and are not permitted. Any attempt by a client to surreptitiously gain access to the therapist's personal sites(s) will be cause for termination of the therapy.

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.

Texas State Board of Examiners of Professional Counselors Complaint Process: An individual who wishes to file a complaint against a Licensed Professional Counselor may write to:
Complaints Management and Investigation Section P.O. BOX 141369
Austin, Texas 78714-1369 or call 1-800-942-5540 to request the appropriate form or obtain more information. This number is for complaints only.

By signing below, you are consenting to treatment from Janice Feuerhelm, LPC

SIGNATURE_____ **DATE**_____

THERAPIST SIGNATURE_____ **DATE**_____

ACCOUNT INFORMATION FOR COUNSELING SERVICES

Accounts: Payment may be made with cash, check or debit/credit card (credit cards will be subject to 2.95 additional convenience fee). 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 $50.00 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.

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Credit Card Authorization for Late Cancellations, No-Shows and any Unpaid Balance: Authorization is given to charge credit/debit cards for late or no-show appointment fees as well as unpaid balances when incurred. Patient understands the appointment policies of this office and assumes responsibility for payment of fees related to late cancellations, no-show appointments or any unpaid balances. 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): ___

The credit card information will be used for the sole purpose of collecting no-show, late cancellation fees and any unpaid balances and will not be used at any other time.

Please sign below indicating that you have read, understand and agree to the information and terms as well as the policy of JCF Counseling for late cancellations and no-show fees.

SIGNATURE_____ **DATE**_____

THERAPIST SIGNATURE_____ **DATE**_____

BELOW FOR OFFICE USE ONLY:
Insurance: _____Date Verified: _____
Plan Year: _____ Deductible Amt:_____Amt Met:_____
Copayment: _____

Janice Feuerhelm, LPC/JCF Counseling Services, PLLC
1324 NW John Jones Drive, Burleson, TX 76028 817-946-5858
HIPPA Notice of Privacy Practices for Personal Health Information

The effective date of this Notice is September 1, 2013. THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities, or collections. For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule. Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. Child Abuse or Neglect, Suicidal. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect, danger to self (suicide). Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process. Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. Medical Emergencies. We may use or disclose your PHI in a medical emergency situation. Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third- party payors based on your prior consent) and peer review organizations performing utilization and quality control. Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an

emergency, or in connection with a crime on the premises. Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm. Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authorization Research. PHI may only be disclosed after a special approval process or with your authorization.With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization:(i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.YOUR RIGHTS REGARDING YOUR PHI You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Janice Feuerhelm, LPC at phone: 817-946-5858. Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person. Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer with any questions. Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period. Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service for out of pocket. In that case, we are required to honor your request for a restriction. Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request. Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself. Right to a Copy of this Notice. You have the right to a copy of this notice. COMPLAINTS If you believe we have violated your privacy rights, you have the right to file a complaint in writing with the Privacy Officer, Janice Feuerhelm, LPC at Address: 1324 NW John Jones Drive, Burleson, TX 76028 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. Acknowledgement of Receipt of Notice of Privacy Practices By signing this form, you acknowledge receipt of the notice of privacy practices of Janice Feuerhelm, LPC/JCF Counseling Services, PLLC. My privacy practice notice provides information about how I may use and disclose health information that I maintain about you.

Adult Client Name: _____Date of Birth: _____

Minor Client Name: _____Date of Birth: _____

Relationship to minor/Date: _____ _____