Esteem Wellness
Counseling / Coaching / Encouraging

Client Information for

Rebecca Easley, LPC

Esteem Wellness at Stone Oak, P.C.

--Confidential—

Date: ___/___/_____ S.S.# _____ - ____ - _____ Birthdate: ___/___/_____ Age:_____

Name: _____
First Middle Last

Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone:	Work Phone:	Cell:
May we leave a message: Y N	May we leave a message: Y N	May we leave a message: Y N

Email Address: _____ May we email you? Y N

Occupation: _____ Employer:_____

Marital Status: __ Married (how long? ___) __ Widowed (how long? ___) __ Divorced (how long?___)
__ Single, never married
No. of Marriages: _____

Spouse Name: _____
First M.I. Last

Spouse's Occupation: _____ Employer:_____

Childs Name	Sex	Age	Living with you?	Relationship to you

Who else, if anyone, shares your residence:

Name	Relationship to you

Religious/Church Affiliation _____

Referred by:_____

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Why are you seeking counseling at this time: _____

_____

_____

_____

How long have you been experiencing this problem? _____

Is this a reoccurring problem? _____ How long since the last occurrence? _____

On a scale of 1-10 (with 10 being the most severe) rate the overall severity of your situation _____

General Health condition:_____

Illnesses/disabilities:_____

_____

Medications – list what condition they are prescribed to treat and how long you have been taking them:

_____

_____

_____

Primary Care Physician: Name _____

Address _____

_____

Phone _____

Date of last visit: _____

Previous Counseling: Name _____

Address _____

_____

Phone _____

Date of last visit: _____

Insurance Information:

Insurance Company: _____ Policy Number:_____

Insurance Telephone Number: _____

Subscriber's Name/Insured Name:_____

Insured SSN: _____ _____ _____ Insured Birth Date: _____

Relationship to client: _____

Please present your insurance card at your first visit.

EMOTIONAL STATUS - Please rate the following items:

	No Problem	Mild Problem	Moderate Problem	Serious Problem
Anger	0	1	2	3
Sadness or depression	0	1	2	3
Anxiety or fear	0	1	2	3
Feeling nothing or feeling numb	0	1	2	3
Mood Swings	0	1	2	3
Less interest in activities	0	1	2	3
Feeling guilty	0	1	2	3
Irritability	0	1	2	3
Feeling happier than usual	0	1	2	3
Thoughts of death or suicide	0	1	2	3
Phobias/Panic Attacks	0	1	2	3
Attention Deficit Disorder/Attention Hyper Activity Disorder	0	1	2	3
Post Traumatic Stress Disorder	0	1	2	3

SITUATIONAL CONCERNS - Please rate the following items:

	No Problem	Mild Problem	Moderate Problem	Serious Problem
Financial Difficulties	0	1	2	3
Legal Issues	0	1	2	3
Difficulties with concentration/memory	0	1	2	3
Restlessness/feeling on edge	0	1	2	3
Withdrawal from friends or family	0	1	2	3
Temper outbursts	0	1	2	3
Avoiding places, people or situations	0	1	2	3
Unable to sit still	0	1	2	3
Intrusive memories or flashbacks	0	1	2	3
Change in appetite	0	1	2	3
Easily fatigued	0	1	2	3
Change in sexual interests	0	1	2	3
Difficulty sleeping	0	1	2	3
Physical pain	0	1	2	3
Change in energy level	0	1	2	3
Alcohol/Drug/Tobacco Use	0	1	2	3
Seeing things that others do not see	0	1	2	3
Hearing things that others do not hear	0	1	2	3
Perpetrator of violence or abuse	0	1	2	3
Victim of violence or abuse	0	1	2	3

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Client Services Contract

COUNSELING OVERVIEW

It is an honor to work with you. The goal of counseling is to equip you with the tools and strategies to deal with your individual challenges. Counseling calls for an interaction between the therapist and the client. In the process, you may experience feelings of anger, fear or frustration. Your therapist will work with you to resolve these issues.

CONFIDENTIALITY

The privacy of all communications between a client and therapist is protected by law, and the therapist can only release information about their work with the client's written permission. There are exceptions:

- **The therapist is legally obligated to take action to protect a child, elderly person or disabled person from abuse by reporting the action to the appropriate state agency.**
- **The therapist will contact family members or others if there is a threat of serious self harm or harm to others. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. In these cases, a more intensive treatment plan will be developed by the therapist, the client, and their family members.**
- **The therapist is legally obligated to release the client's therapy notes (or a summation) if requested by a court of law. This does not include requests from an attorney.**

On occasion the therapist may need to consult with other professionals about treatment of a client. These consultations are conducted without revealing the identity of the client.

Please discuss any questions or concerns regarding confidentiality with your therapist.

MINORS

The therapist is committed to providing confidentiality for adolescent clients. Generalized, non-specific information about the therapy will be provided to the parents/guardians of the adolescent client and parents are involved in the process and participate in formulating the treatment goals. Specific information will be provided to the parent only as approved by the adolescent client.

CONTACTING YOUR THERAPIST

Please leave a message during office hours with the office staff. After office hours, please call the number provided by your therapist. Every effort will be made to return calls in a timely manner. If you are unable to reach your therapist and are in crisis, you are urged to call 911 or go to the nearest emergency room.

PROFESSIONAL RECORDS

The laws and standards for counseling in Texas require the therapist to keep treatment records. These records are confidential and will not be released to anyone without the client's consent. The client may choose not to release these records if they can be emotionally or legally damaging.

PROFESSIONAL FEES

The fee for the initial intake session is $150.00, the hourly fee for individual therapy is $150.00 per session and the hourly fee for family therapy is $150.00 per session. Full payment of the private pay rate or the copayment amount based on your insurance policy is required at the time of service. Insurance must be verified before the first session.

There is a $100 fee for a missed appointment and payment is due no later than the next scheduled session. If you are unable to keep an appointment, please contact the office 24 hours prior to your scheduled appointment, in order to avoid paying the fee for the missed appointment.

LEGAL TESTIMONY

At this time Rebecca Easley MS, LPC, NCC of Esteem Wellness at Stone Oak P.C., does not provide services that involve legal proceedings unless subpoenaed by an official court. All notes, medical records and information pertaining to patients of the above provider are considered confidential unless otherwise notified in writing by the appropriate courts. If it becomes necessary for the above provider to become part of legal proceedings based on a subpoena from the court the fees for said services are as follows:

Daily Rate (testimony): $1000.00/daily (Daily fee does not include per diem, and or travel related expenses. Those will be negotiated in advance).

- **Mileage: $0.55/per mile.**
- **Letter or Report Preparation: $125.00/hour**

FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

This law insures the confidentiality of all electronic transmission of information about the client. Whenever the therapist transmits information about the client electronically (i.e., sending bills and faxing information), it will be done with special safeguards to insure confidentiality. If the client elects to communicate with the therapist by email, please be aware that email is not completely confidential. Any email the therapist received from the client and any responses sent, will be printed and kept as part of the client's treatment record.

Your signature indicates that you have read this document and consent to treatment. This will serve as a contract between you and the provider:

_____ _____

Client Signature **Date**

_____

Client Printed Name

If client is under age 18, parent/guardian consent is required.

_____ _____

Parent/Guardian Signature **Date**

_____

Parent/Guardian Printed Name

_____

Witness