Bluffview Counseling – Therapy Agreement
4240 W. Lovers Ln. Dallas, TX 75209

www.bluffviewcounseling.com
Phone: (214) 390-5800

CLIENT INTAKE, CONSENT, AND INFORMATION FORM

Today's Date _____/_____/_____ **Date of First Appointment** _____/_____/_____

Therapist (check one):

_____ **Gene Klassen, LPC, CSAT, CST x2**
_____ **Jon Juhlin, LPC, CSAT(C), x4**
_____ **Charlie Fisher, LCSW, CSAT, x8**
_____ **Missy Overstreet Desaloms, LCSW, x7**
_____ **Jenny Adams, LPC, CSAT, CPTT x3**
_____ **Jackie Ponder Reynolds, LCSW, CSAT(C) x5**
_____ **Juan Zambrano, LPC, CSAT x9**
_____ **Sarah Gammage-Ramm, LPC-A, CSAT(C)**

CLIENT INFORMATION

Last Name	First	Middle

Address	City	State/ZIP

Primary Phone Number	Alternate Phone Number	Birthdate and Age

Gender (circle one) Male / Female / Other	Marital Status (circle one) Single / Married / Other	Social Security Number

Primary Email Address	Alternate Email Address

Occupation/School	Employer	Annual Household Income

Referred by (please check one box)

□ Family: / □ Friend: _____ □ Therapist: / □ Physician: _____

□ Internet Search, Website: _____ □ Insurance Plan: _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Primary Phone	Alternate Phone

CLIENT CONSENT

CLIENT/THERAPIST RELATIONSHIP: You and your therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILABLE SERVICES: Bluffview Counseling offers a wide array of counseling services, including individual, family, couples, and group services. We are staffed by skilled and experienced licensed clinical social workers. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

COUNSELING: We provide counseling designed to address many of the issues our clients are facing. The goal of Bluffview Counseling is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current therapist are not a good fit, please discuss this matter with your therapist to determine if transferring to a more suitable therapist is right for you. If you and your therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs. Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

EMERGENCIES: If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. You may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If you are experiencing a life- threatening emergency, call 911 or have someone take you to the nearest emergency room for help.

CONFIDENTIALITY: Bluffview Counseling follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you. Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby waive my rights to confidentiality and specifically give consent to my therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name Relationship to Client Primary Phone Alternate Phone

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your therapist. If you must cancel or reschedule your appointment, we ask that you call our office at least 48 hours in advance. This will free your appointment time for another client.

_____(initial)If you fail to notify Bluffview Counseling 48 hours prior to your scheduled time of appointment, you will be charged the full rate for your missed session. Also consider if you are sick that you could request a telehealth session with your therapist to keep the session

PAYMENT/INSURANCE FILING: Payment of fees is expected at the time of each appointment. If you are using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. The 50-minute fees include in-person, telehealth, or telephone sessions.

_____ Yes _____ No - Are you currently receiving Medicare Benefits? If Yes, please get a copy of "Private Pay Contract (Opt -Out)" from your therapist or our website.

FEE SCHEDULES

	INDIVIDUAL or COUPLES (50 min)
JENNY ADAMS	$225.00
CHARLIE FISHER	$225.00
Dr. GENE KLASSEN	$250.00
JACKIE PONDER REYNOLDS	$225.00
JON JUHLIN	$225.00
JUAN ZAMBRANO	$225.00
MISSY DESALOMS	$225.00
SARAH GAMMAGE-RAMM	$225.00

OTHER FEES

Phone Calls in excess of 10 min will be charged	Per min rate as deemed from 50 min rate above
Client Assessments (MAWASI, PTSI-R)	$175.00
Client Assessments (SDI, Gottman Relationship)	$225.00
Copies of client records (minimum charge)	$300.00
Court Appearance – ½ day (Up to 4 hours)	$1400.00
Court Appearance – Full Day (4 to 8 hours)	$2800.00
Returned Check	$40.00

CONSENT TO TREATMENT: By signing this Client Consent Form as the client or guardian of said client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given opportunity to address questions or request clarification for anything that is unclear to me. I agree to receiving a mental health assessment, treatment and services for me, and I understand that I may stop such treatment or services at any time.

_____ _____

Signature – Client **Date**

MINOR CONSENT TO TREAT

Parent #1			
Name	Relationship to Client	Primary Phone	Alternate Phone
Address	City	State/Zip	

You have voluntarily agreed for your child to receive mental health assessment, care, and/or treatment, and you consent to and authorize me to provide said assessment, care, and/or treatment in the manner I consider necessary and advisable. You agree to participate in the planning of your child's care and treatment; you may stop care or treatment at any time.

You waive your right to require me to (a) discuss the details of your child's care and (b) to release your child's records (except billing) to you, unless I deem it in your child's best therapeutic interest to do so. _____Yes _____No

Required Documents (SELECT ONE):

_____ Please attach copies of all custody, conservatorship, and visitation agreements, court orders, and divorce decrees currently applicable to the child.

_____ There are no custody, conservatorship, and visitation agreements, court orders, and divorce decrees currently applicable to the child.

By signing this informed consent to treat form, you acknowledge you have read and understood all the terms and information contained in it and that ample opportunity has been offered to you to ask questions and seek clarifications of anything unclear to you.

Child's Name: _____

Parent's Name (printed): _____

Parent's Signature: _____ **Date:** _____

CREDIT CARD AUTHORIZATION

This form will be securely stored in your clinical file and that you assume the risk for keeping this information on file.

I authorize my therapist, doing business as Bluffview Counseling, to keep my signature and card information on file and to charge therapy session fees (individual, group, workshops, couples, family or other), Cancelled appointments within 48 hours, and any fees related to therapy related materials (workbooks, DVD's, CD's, and other materials) to be charged to my credit, charge, or debit card or flex spending account as filled out below for therapy services provided to:

_____

(Therapy Client's Name: Please Print)

_____ (*initial*) I understand that this authorization is valid until canceled in writing. I understand that though this information is secured in my client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised. I understand that charges for ongoing services or materials will normally be posted to my credit/debit/flex card account within 72 hours of each session date and my session fee will be charged at the start of the day on the day of my session. Additionally, I agree that the card listed below may be charged by therapist above doing business as Bluffview Counseling in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials [e.g. books, CD's, DVD's] that I have not returned within one week of termination. I understand that if a charge back fee is incurred or a retrieval fee is incurred I am responsible for these fees.

_____ (*initial*) I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact therapist above for assistance and/or disclosure. 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 therapist above and those attempts have failed.

_____ (*initial*) Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by therapist above.

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Signature: _____ Cardholder Name [print]: _____

Relationship to client: _____

Card Type (e. g., Visa, Mastercard, AMEX, HSA, Debit): _____

Acct. Number: _____

Exp. Date: _____ Security Code: _____ Billing Zip Code: _____

I understand that my therapy sessions will be charged via this form and not by swiping my card on the morning of my session unless cancelled 24 hours in advance:

Cardholder Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and 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, sending a copy to you in the mail upon request, 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 or disclose PHI so that we can receive payment for the treatment services we provided to you. This will only be done with your authorization. Since we do not participate in insurance billing, this use generally includes billing you directly for services rendered and maintaining records of your payment history, or providing you a superbill for your records. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

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, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, 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 make disclosures of 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.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect
Emergencies
National Security
Judicial and Administrative Proceedings
Law Enforcement
Public Safety (Duty to Warn)

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

- **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 may be 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. We may charge a reasonable, costbased fee for copies.
- **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.
- **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.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **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 Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

NOTICE OF PRIVACY PRACTICES RECEIPT AND ACKNOWLEDGMENT OF NOTICE

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Privacy Practices. I understand that if I have any questions I may contact my primary therapist for clarification.

_____ _____

Signature – Client **Date**

Bluffview Counseling
4240 W. Lovers Ln. Dallas, TX 75209

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Phone: (214) 390-5800

RELEASE OF INFORMATION

Name:_____ **Date of Birth:** _____

_____ Internal (within Bluffview Counseling)
I understand that Bluffview Counseling is a group practice that operates on a team-based treatment model and that, upon entering into treatment with any healthcare provider within said group, information about my treatment may be shared/exchanged with any other healthcare provider employed by or contracted by said group during the course of my treatment. I understand that such sharing of information within the group is for the sole purpose of facilitating my treatment. I understand that under no circumstances shall any provider within the group share information about me or my treatment with any individual or organization outside of the group except where I have authorized below and/or in accordance with the HIPAA privacy policies I have been separately provide with.

_____ External (outside of Bluffview Counseling)
In addition to the above, I hereby authorize Bluffview Counseling, and therefore my therapist(s) employed by or contracted by Bluffview Counseling, to release information about me and my treatment to the following individuals and/or organizations:

Name of person or agency: _____
Relationship: _____
Phone Number: _____
Address: _____
Email _____

Information to be shared – *Circle* FULL CONSENT *or the specific ones that apply:*

progress of treatment discharge summary progress notes other: _____

Purpose for obtaining and releasing information – *Circle all that apply:*

progress reporting legal continuity of care other: _____

Please initial the following:

_____ I understand that I do not have to sign a release form, that signing this form is voluntary.
_____ I understand there are risks and benefits of releasing my confidential information to the above agency/person. One such risk is that releasing information about me gives another agency or person information about my condition and confirms that I have been receiving mental health services.
_____ I understand that this release is limited to what the individual/agency I have written above.
_____ I understand that Bluffview Counseling or its related therapists are not able to control what happens to my information once it has been released to the recipient identified above and that the agency or person receiving my information may be required by law or practice to share it with others.

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either verbally or in writing

_____ _____
Signature **Date**

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address: _____ Physician's Phone: _____

Do you give us consent to discuss your care with the above-named doctor? (Circle one) YES NO

Date of last medical evaluation: _____ Date of next appointment: _____

Please list current medications being taken:

_____ Dosage/Freq_____Start Date_____Purpose _____

_____ Dosage/Freq_____Start Date_____Purpose_____

_____ Dosage/Freq_____Start Date_____Purpose _____

_____ Dosage/Freq_____Start Date_____Purpose _____

Prescribed by: _____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason

Describe any important medical history, chronic ailments, or other health problems you experience:

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

SUBSTANCE USE HISTORY

Do you use recreational drugs? (Circle one) YES NO If no,
have you used previously? (Circle one) YES NO
If yes, when did you stop? _____

Type of Drug	How Much	How Often

Do you drink alcohol? (Circle one) YES NO
If no, did you drink previously? (Circle one) YES NO
If yes, when did you stop? _____

Type of Alcohol	How Much	How Often

Do you smoke cigarettes? (Circle one) YES NO
Do you smoke other types of tobacco? (Circle one) YES NO
If yes, what kind? _____

LEGAL HISTORY

Do you have any current or past legal issues? (Circle one) YES NO If yes,
please explain:

MILITARY SERVICE

Do you or any family members have current or previous military service? (Circle one) YES NO If yes, please explain: (person, unit, branch, time frame, rank)

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle one) YES NO If yes, please explain:

What is the highest level of education you have achieved? _____

If you did not complete high school, please explain:

How would you describe your current support network? (friends, relatives, etc.):

Please circle all information that applies to your biological parents:

MOTHER	Living / Deceased	FATHER	Living / Deceased
	Married / Divorced / Separated		Married / Divorced / Separated
	Remarried _____ times		Remarried _____ times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents?

If so, whom? _____

Where do your parents live?

Mother _____ Father _____

Describe your relationship with your mother while growing up:

Currently:

Describe your relationship with your father while growing up:

Currently:

List first names and ages of your syblings, including yourself:

Name	Age	Relationship (natural, step, half, etc)

Describe any family problems which occurred while growing up relating to: Alcohol/drug abuse:

Describe any sexual/physical/emotional abuse that occurred while growing up:

Describe any significant events you experienced while growing up relating to family problems not noted above, such as deaths of family members or friends, or other personally difficult or sad experiences:

Marital status (Circle one):

Single/never married Separated Divorced Widowed Married Living w/someone

If currently married, when were you married? _____ If living w/someone, how long? _____

Please list your children:

Name	Age	Relationship (biological/step)	Lives with

CULTURAL AND SPIRTUAL PRACTICES

Cultural Background: _____

Religious Preference: _____

How do either of these impact your process of getting treatment?

MENTAL STATUS

Please circle all of the following that describe how you have been feeling lately:

Sad Anxious Depressed Frightened Guilty Angry Ashamed Aggressive Resentful Worthless Tearful Irritable Confused Extreme ups/downs Jealous Hopeless Helpless Describe any other feelings you have had:

What activities or hobbies do you participate in?

Do you participate in regular exercise? (Circle one) YES NO If yes, describe:

Describe your current working environment:

Have you had any change in sleeping habits? (Circle one) YES NO If yes, Describe:

Have you had any change in eating habits? (Circle one) YES NO If yes, Describe:

Have you ever considered suicide in connection to your current problem? (Circle one) YES NO
If so, please give a brief description with dates:

Have you ever considered suicide in the past? (Circle one) YES NO
If so, please give a brief description with dates:

Have you attempted suicide recently or in the past? (Circle one) YES NO
If so, please give a brief description with dates:

Have you had homicidal thoughts recently or in regard to your current problem? (Circle one) YES NO
If yes, please explain:

Have you ever considered homicide in the past? (Circle one) YES NO

If yes, please explain:

LEVEL OF FUNCTIONING

Describe any current impediments or problems in daily psychological, social or occupational functioning (e.g. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, problems with supervisor, etc.):

THOUGHTS: Please check any of the following that apply to you:

_____I sometimes hear voices even though no one nearby is talking to me.

_____I sometimes think that other people or forces outside of me control me and/or my thoughts.

_____I sometimes have the same thought over and over and cannot control it.

_____I sometimes think that someone is out to hurt me or do something against me.

_____I am sometimes unable to control my behavior. Please explain:

Is there any other information regarding you or your family that you would like to share with your therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your therapy goals:

How did you hear about Bluffview Counseling?

THANK YOU!