General Information

Date: _____

Name: _____

Name of Spouse or Parent_____

Address:

_____

_____

Home Phone: _____ok to leave message? ____yes_____no

Cell: _____ok to leave message? ____yes_____no

Work: _____ok to leave message? ____yes_____no

Email_____

Emergency Contact: Name_____Phone:_____

Gender:____ Marital Status:_____ *Race:_____*Ethnicity:_____

***Date of Birth of client:_____**

***Social Security # of client:_____**

***Name of Insured:_____**

***Date of Birth of Insured:_____**

***Social Security # of Insured:_____**

Occupation:_____

needed for insurance purposes

Description of
Problem:_____
_____
_____

Members of Household:
Name: Age: Attending First Session?
_____
_____
_____
_____
_____

Please list all medications you are currently taking: _____

_____

Doctor:_____Phone number:_____

Is there a lawsuit pending, or is there a probability of a lawsuit being filed regarding this problem?_____if yes, please explain: _____

_____

Have you or any family member ever been involved in therapy or any other type of counseling program?_____If yes, when?_____

Where?_____Reason:_____

_____

Have you or any other family member ever been hospitalized for any mental health reasons?_____If yes, who?_____

When?_____Why?_____

Have you or any other family member ever been, or are currently being treated for any type of chemical dependency/abuse? _____ If yes, who?_____

What substances?_____

Have you or any family member ever been arrested/committed a crime?_____ for what?_____

Have you or a family member ever attempted suicide?_____When?_____

if yes, who_____was treatment received?_____

Important religious or cultural information:_____

If client is a student: What school? _____ _____ Grade? _____

Please list any school issues/concerns:_____

Informed Consent

Jennifer Kelly Guillette, MA, NCC, LPC-S

I am sincerely glad that you are here. I am committed to providing you with quality service. You will be learning about the counseling services and policies during your first session, and you will have the opportunity to ask any questions that you may have. This document is designed to insure that you understand your rights and our professional relationship.

Therapist background and orientation:

Jennifer Kelly Guillette, MA, NCC, LPC-S holds a Bachelor of Science in Criminal Justice in Corrections, and a Master

of Arts degree in Counseling from Sam Houston State University. Ms. Guillette is a national certified counselor. She is a Licensed Professional Counselor and a LPC Supervisor. She has worked in East Texas and in the Dallas area providing counseling services to children, adolescents, and adults. She has collaborated with several agencies and developed a significant network of resources to assist families. In her work with individuals and families she incorporates various cognitive and behavioral theories with experiential training to encourage change. Ms. Guillette has provided services for children, adolescents, and adults in inpatient and outpatient settings. She has worked with individuals with presenting problems as diverse as depression, bipolar disorder, ADHD, anxiety, sexual problems, abuse issues, substance abuse, work related issues, psychosis, and adjustment and coping difficulties. She has worked in a psychiatric hospital, with community mental health agency, residential treatment center, and in the private practice setting.

Jennifer Guillette, MA, NCC, LPC-S accepts most insurances and clients with private pay.

<u>Your Rights as a Client:</u>

1. You have the right to decide not to receive psychotherapy from me. If you wish, I will provide you with the names of other qualified psychotherapist.

2. You have the right to end therapy at any time without moral, legal, or financial obligation other than the payment of fees for services rendered.

3. You have the right to ask any question about the procedures used during therapy. If you wish, I will explain all therapeutic procedures and their rationales to you.

4. You have the right to prevent electronic recording of the therapy sessions. Occasional tape recording of a therapy session is used for the purpose of review in order to maximize the benefit of your therapy time. However, you have the right to withdraw your permission to record at any time.

5. You have the right to review your records at any time.

6. You have the right to have the information revealed in therapy kept strictly confidential, except as described in the section below.

7. You have the right to have any part of your record released to any persons or agencies you designate. I will tell you at the time whether or not I think making the record public will be harmful to you.

8. You have the right to address any complaints against any LPC to the Texas State Board of Examiners of Professional Counselors, 1100 West 49th. Street, Austin, Texas 78756-3199,(512) 834-6658

<u>Nature of Counseling</u>

In my private practice I only accept clients who I believe have the capacity to resolve their own problems with my assistance. My desire is to help you resolve the problems that brought you in for counseling as quickly as possible. Some clients need only a few counseling sessions to achieve their goals while others may require months to overcome their difficulties. A few clients may need a long term relationship with me in order to function adequately in the outside world. When counseling is successful, you should feel that you are able to face life's challenges without regular contact with me. Of course, as situational and developmental issues arise in the course of living, I will always be happy to see you for a counseling checkup.

Although our sessions may be very intimate emotionally and psychologically, it is important for you to know that

we have a *professional relationship* rather than a personal one. Our contact will be limited to the paid sessions you have with me. While I appreciate invitations to social gatherings and gestures of caring such as gifts from clients, it is inappropriate for me to relate to you in any way other than in the professional context of our counseling sessions. You will be best served if our relationship remains strictly professional and if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling experience. However, it is important for you to remember that you are experiencing me only in my professional role.

It is inevitable that I will see some clients or former clients in the community, church, or social functions. In such cases, I leave it up to the client or former client to set the tone of our interaction in that setting. I will not indicate any prior knowledge of you, and in no case will I say anything that would indicate to others present that you have had a counseling relationship with me. This is done in order to preserve confidentiality regarding your counseling.

<u>Confidentiality:</u>

All information about your treatment is kept with strict confidentiality except for the conditions listed below, to protect you.

<u>Procedures:</u>

The following procedures will be adhered to:

1. Written, telephone, or personal inquiries about you will not be acknowledged. You must sign a release of information before any information about you is given to anyone outside of this office. Even then, I may advise you to withhold information if I feel it is in your best interest.

2. All records, tapes, and other identifying materials are kept confidential.

3. When families are involved in family therapy (this does not apply to individuals in therapy,) they agree to a modification of the traditional rules of confidentiality in order to allow the therapist the freedom of inquiry necessary to optimally serve them. Specifically, the therapist must be given the freedom to reveal to other family members what has been told by one family member so that the therapist will have full opportunity to explore all points pertinent to the therapeutic process. While I will respect your privacy and will not automatically reveal all information provided, I reserve the right to make such revelations if I consider them warranted for the purpose of aiding the family in overcoming presenting problems which brought them into therapy.

4. When working with children and adolescents it is extremely important to build trust. Therefore anything told to me in the session with the child will be held in strict confidence unless given express permission by the child to share it with the parent/caregiver.

5. Confidentiality and privileged communication are the rights of all clients and we exercise every effort to maintain these rights. Information included in your file is shared only with Ms. Guillette and her filing staff. Should information be requested from a source outside of these people, the client's written permission will be requested before such information is sent. However, I may release information without your consent if the law requires that I do so. This includes:

1. Where a court order is received.

2. If there is an emergency that threatens the client's life, the life of another, or if there is a probability of

immediate mental or emotional injury to the client.

3. If there is evidence of child abuse and/or neglect.

I will make every effort possible to notify the client in advance before a release of information takes place.

<u>The Risks of Counseling</u>

The greatest risk of counseling is that it may not by itself resolve your problems or concerns. Thus, I assess progress on a week to week basis. Chronic non-improvement is treated as a reason for immediate referral. Also, be aware of the risk of only one person attending therapy and that it may adversely affect the marital relationship. That is why we encourage the entire family to participate in family or marital therapy.

I have chosen to discuss the risks of counseling out of an ethical commitment to help you make an informed choice to participate with me in addressing your concerns. In fact, this commitment will continue throughout your treatment. At any time you may ask why I am gathering information or utilizing a new approach. I will be happy to explain the purpose behind my techniques.

<u>Appointments for therapy</u>

It is your responsibility to notify me at least 24 hours in advance if you will not be able to keep your scheduled appointment. If you cancel an appointment with less than 24 hour notice or do not show up for a session you will be billed the regular session fee. If the client has not called or attended his/her scheduled session time any other scheduled sessions will be cancelled.

If no notice is given, or if less than 24 hours' notice is given to cancel an appointment, you will be charged your regular session fee. If you have not called the therapist about the missed appointment all other scheduled sessions will be cancelled. _____client's initials.

<u>Termination of therapy</u>

You may terminate therapy in any of the following ways:

1. Verbal or written notification.

2. Missing two consecutive appointments without 24 hours' notice.

3. Threatening or abusive remarks or behaviors.

4. Not paying agreed upon fees for services rendered.

5. Failure to follow my recommendations regarding crucial issues of physical health, safety, and crisis situations (i.e. medical referrals, suicide interventions, etc.)

Of course, the client may choose to leave therapy at any time, but this is best accomplished in consultation with the therapist. If the client is dissatisfied with the course of therapy, I encourage you to talk with me. I will try to resolve the problem or will provide you with referrals to other appropriate professionals.

<u>Subpoenas to Court</u>

In family disputes that result in legal actions by one or more family members, it is almost always inappropriate for Ms. Guillette to be subpoenaed to testify since her focus is on helping families and individuals to find their own

strengths and resources to overcome various crises. The focus of Ms. Gillette's work is NOT on the kinds of assessments that are appropriate in legal disputes such as child custody battles. Therefore, all family members participating in counseling agree that they will not have their attorney subpoena Ms. Guillette to testify in such cases unless previously agreed on. If Ms. Guillette is subpoenaed to testify she charges a $2500 retainer fee. Her hourly fee is $300 an hour (one hour minimum) plus expenses paid in advance of her testimony._____client's initials

Crisis

In a crisis situation the therapist can be reached via voice mail. Call the office number (903.253.1633) and leave a message as to the nature of the crisis, and Ms. Guillette will return your call as soon as possible (usually within 24 hours.) If the crisis is extreme and or danger is imminent, call the police or go the local Emergency Room.

Fees

Fees are due at the beginning of each session. If you do not keep your agreement to pay the agreed upon fees in a timely manner, the therapy will be terminated. Any balance due must be paid before returning to therapy. After three months, all unpaid balances are forwarded to a collection agency. _____client's initials

Insurance

The therapist will file with your insurance company for you. This does not negate the fact that you are solely responsible for your balance. Most health insurance companies will require that I diagnose your mental condition and indicate that you have an illness. Any diagnosis made will become part of your permanent insurance records.

If after 2 months of filing with your insurance, they have not rendered payment to the therapist, it will be your responsibility to pay the balance owed and be reimbursed by your insurance carrier. _____client's initials.

Credit Card Authorization:

"I authorize Jennifer Guillette, MA, NCC, LPC-S to charge my credit card for payments of services, co-pays, and/or 24 hour cancellation policy violation fees unless otherwise paid for by me at the time of service."

Credit Card #_____

Expiration Date_____ Billing zip code:_____3 digits on back of card_____

Name on Card:_____

Signature:_____Date:_____

Consent for Services

I understand that there is no guarantee that therapy will resolve my problems and that there are risks involved in therapy. I will take responsibility for discussing with my therapist either the absence of meaningful change or

discomfort that I may have with the course of therapy.

I understand the confidentiality policies previously stated and agree to them, particularly in regard to the limits of confidentiality relative to other family members in family counseling.

I authorize the release of my records to my insurance carrier or other referring agencies if requested by them. If a physician has referred me, I authorize the release of records to them upon request. RECORDS WILL NOT BE RELEASED TO CLIENT. I understand that records provided to insurance carriers include a diagnostic category.

I understand that it is my responsibility to pay fees for services rendered. Any dispute with my insurance carrier over payment is my responsibility to resolve and does not relieve me of my obligation to pay Ms. Guillette.

During the course of my treatment, I hereby authorize payment directly to Jennifer Guillette, LPC-S by my insurance provider.

I understand that appointments not cancelled with 24 hours' notice will be billed directly to me, not my insurance carrier.

I have read and understand the statements on the previous pages of the New Client Packet. My signature below indicates that I give my full and informed consent to receive services.

_____

_____

Client/Parent/Guardian's Signature Date

if client is a minor both parents must sign consent for services unless otherwise specified in court orders