Dallas Rainbow Counseling

Rebekka Ouer, LCSW
214.616.5082

Individual/Family Counseling Intake Form

General Information: Date: _____

Client Legal Name: _____ Phone: _____ Age: _____

Client Preferred Name: _____ Alternate Phone: _____

Guardian Name (if client is under 18): _____ Voice Messages Okay? ❑ Yes ❑ No

Address: _____

E-mail: _____

Client Occupation: _____

Guardian Occupation: _____

Is the client currently in counseling elsewhere? ❑ Yes ❑ No

*****If yes, please stop here and speak with Rebekka before completing the remainder of the form.***

How were you referred to our office? _____

Client's relationship status? ❑ Single ❑ Committed Relationship ❑ Partnered ❑ Engaged ❑ Cohabitating ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

How long has the client been in this relationship? _____

Briefly describe your hopes from counseling: _____

_____

_____

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Individual/Family Counseling Intake Form (cont'd)

Health and History Information:

Any concerns shared by the client's doctor? _____

Has the client struggled with substance abuse or dependence? ❑ Yes ❑ No

Please describe: _____

Has the client struggled with substance abuse or dependence? ❑ Yes ❑ No

Please describe: _____

Does the client have a mental health diagnosis? ❑ Yes ❑ No

Please describe: _____

Is the client currently under the care of a Psychiatrist? ❑ Yes ❑ No

List all current prescribed medications of you have taken by the client in the last year: _____

_____

_____

List ***any*** significant illnesses, important accidents and injuries, grief and loss, or ***any other*** major changes or events you feel I should be aware of: _____

_____

_____

_____

Please provide ***any other*** information you feel is helpful for me to know about the client**:**

_____

_____

_____

_____

Individual/Family Counseling Intake Form (cont'd)

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Please Answer the Following:

- Has the client ***ever*** attempted suicide or harmed themselves in ***any way***? ❑ Yes ❑ No
- Has the client had any thoughts in the past few ***days or weeks*** of suicide or harming themselves in ***any way***? ❑ Yes ❑ No
- Is the client ***currently*** thinking about suicide or harming themselves in ***any way***? ❑ Yes ❑ No
- Is the client having ***any*** thoughts about harming ***anyone else*** in ***any way***? ❑ Yes ❑ No

Please elaborate here if necessary**:** _____

_____

_____

_____

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Professional Disclosure Statement and Informed Consent

PLEASE CAREFULLY READ EACH ITEM:

- I understand that Rebekka Ouer, LCSW is licensed to provide counseling and family therapy in the state of Texas.
- I understand that Rebekka Ouer, LCSW does not provide 24-hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1 or go to an emergency room for assistance.
- I understand that during the time that we work together, we will meet regularly for approximately 50-60 minutes. While our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one.
- I also understand our contact will be limited to counseling sessions. Only in cases of emergency, or the need to cancel or reschedule, I will call the phone number provided.
- I understand that, at any time, I may initiate a discussion of possible positive or negative effects of entering into the counseling relationship and specific results are not guaranteed although benefits are expected from counseling.
- I understand that counseling can improve as well as upset the equilibrium in any person or family. Counseling is a personal exploration and may lead to changes in my life perspectives and decisions. These changes could be temporarily distressing.
- I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship. If at any time I am dissatisfied with my therapist, I have a right to let them know. If I do not feel that Rebekka Ouer, LCSW resolved my complaint, I may file a formal complaint through contact with the Texas Board of Examiners at 1-800-942-5540.
- I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality, and because of this my therapist cannot initiate greetings.
- Should I believe that a referral is needed, my therapist will provide some alternatives including programs and/or people who may be able to assist me per my request.
- I understand that the rate for individual or couples counseling sessions is $150.00 for a 50-60- minute session.
- I understand that all fees for counseling are due after each session.
- I understand that the rate for all subsequent therapy services such as: attending parent/teacher conferences, attending ARD meetings, conducting classroom observations, participating in legal depositions, interactions with insurance companies, phone calls over 5 minutes, etc. will be billed at $150 per hour in 10-minute increments.

- I understand that conducting expert witness and testimonial services are **not** an area of interest for my therapist. Should my therapist be subpoenaed as a factual case witness or involved in any court-related processes a retainer fee of $1,500 is required, with an additional $240 every hour they are involved in legal depositions, case preparation, travel, and witness time.

- I understand that if I do issue my therapist a subpoena without approval (see above) that my subpoena will be directly turned over to the staff attorney and a bill will be rendered to me for immediate retainer fee payment.

- I understand that if a check is returned, a processing fee of $25 will be assessed to my account. Additionally, I will need to make a cash or money order payment for the returned check and the $25.00 processing fee. After a returned check, payment may be required via cash for future appointments.

- I understand that if a returned check is not cleared up in 30 days, my therapist will file a suit with the Dallas County District Attorney's Office.

- **I understand that I am responsible for any appointments that are not cancelled at least 24 hours prior to my appointment time, with the EXCEPTION OF AN EMERGENCY.**

- **I understand that if I do not cancel my appointment 24 hours ahead of time, the fee for calling to cancel on the day of my appointment is $60.**

- **I understand that if I do not show up for an appointment, it will result in my being charged $150 for the full missed session.**

- I understand that my records and all of our communications become part of the clinical record. Records are the property of Uptown Counseling and Family Therapy. All client records are disposed of seven (7) years after the client has stopped receiving services.

- I understand that while most of our communication is confidential there are circumstances when disclosure can occur without my prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

    - You are a danger to yourself or someone else.
    - In situations of suspected child, spouse, or elder abuse, it is the duty of the mental health provider to notify medical, legal, or other authorities.
    - You disclose sexual contact with another mental health professional.
    - If you are involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
    - Your UCFT therapist is ordered by a court to disclose information.
    - You direct your UCFT therapist in writing to release your records.
    - Your therapist is otherwise required by law to disclose information.

STATEMENT OF UNDERSTANDING

I have read the above and understand the nature of service providers and the Limits of Confidentiality outlined and I solemnly swear that all of the above information is true to the best of my knowledge.

_____

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Client Signature Date

AGREEMENT FOR THERAPY

I,

_____

- ❑ I agree to receive therapeutic services provided by UCFT.
- ❑ I have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services and the risk and benefits of not receiving these services, for both my family and myself.
- ❑ I acknowledge that I have received and understand the Notice of Privacy Practices for this office.

_____

Client Signature Date

HEALTH PROVIDER'S STATEMENT

I have inquired to ensure that the patient understood the above description of the limits on confidentiality.

_____

CLINICIAN SIGNATURE Date

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HIPPA 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 it carefully. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I acknowledge that I have read and understood the HIPPA Notice of Privacy Practices for this office:

Client Signature Date

Consent for Use and Disclosure of Health Information:

I hereby permit and release UCFT to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, POs, managed care organizations, IPAs, or other governmental or third party payers, or any organization contracting with any of the above entities to perform such functions.

Client Signature Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent