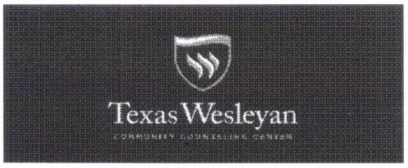

Texas Wesleyan University Community Counseling Center

3110 E. Rosedale
Fort Worth TX 76105
8175314859

1. Client Details

CONTACTS

CLIENT'S FULL NAME:

HOME PHONE:

MOBILE PHONE:

WORK PHONE:

EMAIL ADDRESS:

ADDITIONAL EMAIL ADDRESS (OPTIONAL):

WHEN CONTACTED (PLEASE CHECK ALL THAT APPLY):

- ☐ DO NOT MENTION CENTER'S NAME
- ☐ DO NOT CONTACT BY PHONE CALL
- ☐ DO NOT CONTACT BY TEXT MESSAGE
- ☐ DO NOT CONTACT BY EMAIL

ADDRESS (PLEASE INCLUDE STREET, APT #, CITY, ZIP, COUNTY, STATE):

AVAILABLE DAYS AND TIMES:

HOW DID YOU HEAR ABOUT US?:

EMERGENCY CONTACT

FULL NAME:

RELATIONSHIP:

PHONE NUMBER:

ADDITIONAL PHONE NUMBER (OPTIONAL):

DEMOGRAPHICS

BIRTHDATE:

LEGAL GENDER:

PREFERRED GENDER:

GENDER IDENTITY (OPTIONAL):

PREFERRED IDENTITY (OPTIONAL):

SEXUAL ORIENTATION (OPTIONAL):

RACE (OPTIONAL):

MARITAL STATUS:

RELIGION (OPTIONAL):

EMPLOYMENT:

EMPLOYER:

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3. Standard Intake Questionnaire

Full Name:

What is your major concern?:

On a scale of 0 (meaning no problem) to 10 (Meaning Very Severe), How severe is the problem?:

Have you previously suffered from this concern?:

If Yes, Are you currently under treatment of another therapist, counselor, or pscychiatrist? Please list their name and contact information:

What has been helpful in the past?:

What has been harmful in the past?:

Current Symptoms

(check all that apply)

- ☐ Anxiety
- ☐ Appetite Issues
- ☐ Avoidance
- ☐ Crying Spells
- ☐ Depression
- ☐ Excessive Energy
- ☐ Fatigue
- ☐ Guilt

- [ ] Hallucinations
- [ ] Impulsivity
- [ ] Irritability
- [ ] Libido Changes
- [ ] Loss of Interest
- [ ] Panic Attacks
- [ ] Racing Thoughts
- [ ] Risky Activity
- [ ] Sleep Changes
- [ ] Suspiciousness

- [ ] Other

If Other, Please Specify:

Medical History

Exercise Frequency:

Exercise Type:

Allergies:

What medications are you currently using?:

Previous diagnoses/mental health treatment:

Previous medical conditions:

Previous surgeries:

Current Physician's Name and Phone Number:

Family History

Siblings and their ages:

Are your parents married? Cohabitating?:

Did your parents divorce/break-up? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who primarily raised you? Where did you grow up?:

Family member MEDICAL conditions:

Family member MENTAL conditions:

Present Situation

Work:

Are you married? Divorced? Seperated? Remarried? Widowed? Cohabitating? Please Specify, and include year of event (i.e. married, 2015)?:

Partner's Name and Contact Number :

Do you have child(ren)? If yes, what are their names and ages?:

Are you a member of a religion/spiritual group?:

Have you ever tried the following?

(check all that apply)

- ☐ Tobacco
- ☐ Marijuanna
- ☐ Hallucinogens (LSD)
- ☐ Heroin
- ☐ Methamphetamines
- ☐ Cocaine
- ☐ Stimulants (Pills)
- ☐ Ecstasy

- [ ] Methadone
- [ ] Tranquilizers
- [ ] Pain Killers
- [ ] Not Listed

Not Listed, Please Specify:

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

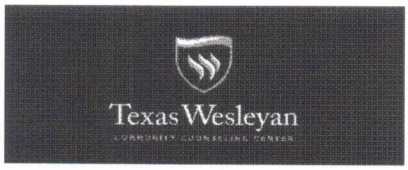
Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

Additional Informtation

Is there any additional information that you would like to include on this form?:



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4. Informed Consent Counseling Service Agreement

***** Confidential resources are University employees who are not obligated to share any personal identifying information about a report of sexual violence (such as the survivor or accused name) with law enforcement, the Title IX Coordinator or any other University administrator. Confidential resources are: Anice Lewis- Hollins (Director of Health Services: 817-531-4948).*****

If primary client is a minor OR if minors present at ANY time, the parent/guardian/ conservator must read, initial and sign this form AND "Requirements for Parental Consent of Minors."

THERAPEUTIC PROCESS

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process.The therapeutic process provides an opportunity for self-examination and positive change.

The therapeutic relationship is unique in that it is a highly personal and a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of each topic and signing in the space provided at the end of the document.

☐ I(We) have read and understand the benefits of "The Therapeutic Process".

CONFIDENTIALITY AND COUNSELING RECORDS

Interns and/or supervisors may exchange any/all information obtained with counseling staff. All digital recording is confidential according to Texas State law and ethical guidelines of Texas counseling licensing boards - Texas State Board of Examiners of Professional Counselors, and Texas State Board of Examiners of Marriage and Family Therapists (TDSHS), AAMFT and ACA. All digitally recorded material is kept in a secure, locked area. Under HIPAA, disclosure of counseling records is permitted by law without your authorization or consent when ANY of the following conditions exist:

1. Reasonable suspicion of abuse/neglect of children/elderly reportable to Child/Adult Protective Services

2.) where you present a serious danger/threat to yourself or others (homicide, suicide), reportable to anyone who is reasonably able to prevent or lessen the danger/threat

3.) if your records are under subpoena by a court of law

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions outside of our session time.

I (We) also understand that if I request my records, none will be transmitted electronically or by fax. After written consent is obtained, I will physically pick up my records at the Texas Wesleyan University Community Counseling Center within fifteen (15) days of my request during normal business hours.

I (We) give my consent to be called on my cellular phone, or sent a text by my counselor. I understand that no clinical information will be transmitted through these devices.

☐ I(We) have read and understand the policy on confidentiality and counseling records.

RESEARCH

Evaluation information that may be used in current or future research projects. Participation in this research is voluntary and you may withdraw your consent which will in no way affect our service to you. Publications resulting for this research will not contain any identifying information and your confidentiality will be strictly maintained.

☐ I(We) have read and understand the research statement and consent to my(our) personal Information being used for research purposes.

APPOINTMENTS – CANCELLATIONS, NO SHOWS, RESCHEDULING

Sessions will last 45-50 minutes and are voluntary. If you are late for your appointment, the session will still end at the top of the hour. If you encounter time constraints, please contact your therapist as soon as possible to reschedule. A no show appointment may result in being reassigned to another therapist or being placed back on the waiting list.

☐ I(We) have read and understand the "Appointments - Cancellation, no show and rescheduling".

24 HOURS CANCELLATION NOTICE and RESCHEDULING WITHIN 48 HOUR IS REQUIRED

Do this so your next available appointment will be at your regular time. Missing a scheduled appointment and not rescheduling within 48 hours will result in your case being closed. As a courtesy, your therapist may call and leave a message to the number you provide for you to call and reschedule. The center will

not communicate clinical information via e-mail or cell phone.

☐ I(We) have read and understand the "24 hour cancellation notice and rescheduling within 48 hours".

DIGITAL RECORDING/LIVE OBSERVATION

Intern therapist are supervised by licensed professional counselors and licensing board-approved supervisors and are under peer review for providing valuable feedback to improve counseling skills. All sessions at the center are digitally recorded. Some sessions may be observed live behind a one-way mirror as well.

☐ I(We) have read and understand the policy on "digital recording, live observation, and consent to digital recording and/or live observation during my(our) counseling sessions.

FORENSIC SERVICES

We do not perform "forensic services" (child custody, disability claims, assessments for legal purposes, psychological/psychiatric evaluations) and CANNOT provide forensic opinions, reports, assessments, or recommendations according to Rule 465.18 Texas Administration Code, Title 22.

☐ I(We) have read and understand the policy on "Forensic Services"

SLIDING SCALE FEE

☐ Check the box if you are a Wesleyan Student, Faculty/Staff, or Alumni (Includes spouse/partner and dependents) Fee is $0

To Estimate Fee, we will need to know your Household Annual Income (Estimate you do not need to bring in proof) and Household Size (How many people live in your home, including all dependents and yourself). The therapist will go over the amount you will have to pay. Below will show the range per Annual Income. Please remit payment by mail either check/money order or in person to: Texas Wesleyan University Community Counseling Center 3110 E. Rosedale Fort Worth Texas 76015 PH:817 531 4859

Annual Household Income:

Household Size:

0 - 15,000 ($10)1 - 9 Family members $10 Students Faculty Alumni NO FEE

16,000 - 25.000 ($15 -10) 1-3 (15), 4 (14), 5 (13), 6 (12), 7(11), 8&9 (10)

26,000 - 30,000 ($20 - 10) 1-3 (20), 4 (18), 5 (16), 6 (15), 7(12), 8&9 (10)

31,000 - 40,000 ($25 - 10) 1-3 (25), 4 (12), 5 (20), 6 (17), 7(15), 8&9 (10)

41,000 - 50,000 ($30 - 10) 1-3 (30), 4 (25), 5 (20), 6 (17), 7(15), 8&9 (10)

51,000 - 60,000 ($35 - 10) 1-3 (35), 4 (30), 5 (25), 6 (20), 7(15), 8&9 (10)

61,000 - 70,000 ($40 - 10) 1-3 (40), 4 (35), 5 (30), 6 (25), 7(20), 8&9 (10)

71,000 + ($50 -10) 1-3 (50), 4 (45), 5 (40), 6 (35), 7(20), 8&9 (10)

Signature of Client or Guardian of Client (please type):

DOB:

Signature of Spouse / Partner / Other Family Member (please type) If participating in services::

DOB of Spouse / Partner / Other Family Member If participating in services::

Signature of Other Family Member (please type and indicate relation to you) If participating in services::

DOB of Other Family Member If participating in services::

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5. HIPAA Privacy Statement

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

Texas Wesleyan University Community Counseling Center understands that information about you and your health care is personal.We are committed to protecting health information about you. This notice applies to all of the records of your care generated by this mental health care facility this notice will tell you about the ways in which we may use and disclose health information about you.This document describes your rights to the health information, and describes certain obligations that we have regarding the use and disclosure of your health information. We are required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- Changes can be made to the terms of this Notice, and such changes will apply to all information on file about you. The new notice will be available upon request in the office of Texas Wesleyan University Community Counseling Center, and through online services.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose health information.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations.We may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the

coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. We do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
a. For my use in treating you.
b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
c. For my use in defending myself in legal proceedings instituted by you.
d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
e. Required by law and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AURTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others.We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us not to use or disclose certain PHI for treatment, payment, or health care operations purposes.We are not required to agree to your request.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How We Send PHI to You. You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request.
5. The Right to Get a List of the Disclosures we have made. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

Signature of Client or Guardian of Client (please type):

D.O.B. of Client or Guardian of Client (please type):

Signature of Spouse / Partner / Other Family Member (please type) If participating in services::

D.O.B. of Spouse / Partner / Other Family Member (please type) If participating in services::

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6. Informed Consent for Telemental Health Services

This document is an addendum to the Texas Wesleyan University Community Counseling Center standard informed consent and does not replace it. All aspects of informed consent for treatment in that document apply to telemental health (TMH) treatment. TMH refers to counseling sessions that occur via phone or video conference using a variety of technologies. TMH is offered to improve access to counseling services. However, the results of Texas Wesleyan University Community Counseling cannot be guaranteed or assured. You are not required to use Texas Wesleyan University Community Counseling Center and have the right to request other service options or withdraw this consent at any time without affecting your right to future care or treatment at Texas Wesleyan University Community Counseling Center. Texas Wesleyan University Community Counseling Center's services may not be appropriate, or the best choice of service for reasons including, but not limited to: heightened risk of harm to oneself or others; lack of access to, or difficulty with, communications technology; significant communications service disruptions; or need for more intensive services. In these cases, your counselor will help you establish referrals to other appropriate services.

TMH services are conducted and documented in a confidential manner according to applicable laws in similar ways as in- person services. There are, however, additional risks including:

• Sessions could be disrupted, delayed, or communications distorted due to technical failures.

• TMH involves alternative forms of communication that may reduce visual and auditory cues and increase the likelihood of misunderstanding one another.

• In rare cases security protocols could fail and your confidential information could be accessed by unauthorized persons.

Texas Wesleyan University Community Counseling Center works to reduce these risks by using secure video conferencing software and these policies and procedures:

• You may only engage in sessions when you are physically in the state of Texas. Your clinician will confirm this each session.

• You and your clinician will engage in sessions only from a private location where you will not be overheard or interrupted.

• You will ensure that the computer or device you use has updated operating and anti-virus software.

• You will not record any sessions, nor will Texas Wesleyan University Community Counseling Center will

not record your sessions without your written consent.

• You will provide contact information for at least one emergency contact in your location who Texas Wesleyan University Community Counseling Center may contact if you are in crisis and your counselor is unable to reach you:

Please type name, phone number, and relationship below: :

Should there be technical problems with video conferencing, the backup plan is contact by phone. Make sure that Texas Wesleyan University Community Counseling Center has a correct phone number at which you can be reached, and have your phone with you at session times. If you are unable to connect, or get disconnected, please try to connect again and if you continue to have problems your clinician will contact you . If you choose to contact your clinician by text or email, do not include private information, and do not expect a prompt response. Client communications may be viewed by other staff at Texas Wesleyan University Community Counseling Center. E-mail and text communications will be stored electronically as treatment records. If we believe you are in crisis and we are unable to contact you, we may call your emergency contact or local emergency services providers.

In some limited circumstances, or to preserve continuity of care, sessions by phone may be arranged. Please be aware that phone communication may not be secure. If you have concerns about phone sessions, please discuss these with your clinician.

Texas Wesleyan University Community Counseling Center cannot provide 24-hour emergency management, particularly to those using services at a distance. If you are ever experiencing an emergency, including a mental health crisis, you agree to:

MHMR 24/7 ICARE Call Center 817 335 3022 (call or text) 1 800 866 2465 (toll free)

Suicide and Crisis Center of North Texas 214 828 1000 Text GO to 741741 Text Crisis 24 hr. Line Confidential

JPS Psychiatric Emergency 817 702 4151

Spanish Crisis Line Mental Health America 1 888 628 9454

Hearing Impaired 1 800 799 4889

In case of emergence call 911

I have read and understand the above information and all my questions have been answered. I hereby give informed consent to use Telemental Health in my care.

Signature of Client or Guardian of Client (please type):

D.O.B. of Client or Guardian of Client (please type):

Signature of Spouse / Partner / Other Family Member (please type) If participating in services::

D.O.B. of Spouse / Partner / Other Family Member (please type) If participating in services::