Stone Oak Counseling
Janet A. Harrison, LPC-S LMFT-S

18834 Stone Oak Parkway, Suite 104, San Antonio, TX 78258

CLIENT INFORMATION

Client Name _____
(Last) (First) (Middle Initial) (Nickname)

Home Address _____
(Street) (City) (State) (Zip)

Home #: _____ Cell #:_____ Wk #:_____

Email address: _____ Soc Sec #: _____ Birthday: _____

Employer/School: _____ Occupation/Grade: _____

Referred By: _____

RESPONSIBLE PARTY/INSURED'S INFORMATION

Name: _____ Birthday: _____
(Last) (First) (Middle Initial)

Home Address _____
(if different than client) (Street) (City) (State) (Zip)

Home #: _____ Cell #:_____ Wk #:_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Name of Insurance Company: _____

Insured's ID/Policy #: _____ Social Sec #: _____

Employer: _____ Phone: _____ Occupation: _____

ALL FEES ARE DUE AT THE TIME OF THE APPOINTMENT. Fees are due for any scheduled appointment unless the appointment is cancelled forty-eight (48) hours in advance. Messages can be left on my confidential voice mail at (210) 863-2304.

_____ I authorize the release of any medical information requested by my insurance company that is necessary to process my claims for services rendered.

_____ I authorize payment be made to this provider for services rendered either by my insurance or myself.

SIGNED: _____ Date:_____

Briefly describe why you are seeking counseling:

_____

Rate the following items on how much of a problem they have been for you over the past year:

	No Problem	Mild Problem	Moderate Problem	Serious Problem
Anger or Irritability	0	1	2	3
Sadness or Depression	0	1	2	3
Anxiety or Panic Attacks	0	1	2	3
Mood Swings	0	1	2	3
Relationship difficulties	0	1	2	3
Difficulties with concentration/memory	0	1	2	3
Sleeping difficulties	0	1	2	3
Alcohol or drug use/abuse	0	1	2	3
Thoughts of death or suicide	0	1	2	3

Have you seen a Counselor or Psychiatrist before? ☐ Yes ☐ No If so, when ?

_____

Are you presently taking any medication(s)? ☐ Yes ☐ No

If yes, which ones?_____

Please list all individuals currently living with you.

Name	Relationship	Gender	DOB	Occupation/Grade

APPOINTMENT CONFIRMATION CONSENT:
Please provide us with the number(s) you would prefer us to use to confirm your appointment. Confirmation text messages will be sent 48 hrs. in advance as a courtesy to you. The absence of our confirmation is not a justifiable reason to miss your scheduled appointment.

Reminder Cell Phone Number to be used for text message: _____
(You will be prompted to enter a code to confirm or cancel)

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COUNSELOR-CLIENT CONTRACT AND INFORMED CONSENT

Qualifications/Experience:

I have a Master's degree in counseling from St. Mary's University with a specialization in Marriage and Family Therapy. I am licensed as a LPC (Licensed Professional Counselor) and LMFT (Licensed Marriage and Family Therapist) by the state of Texas. I began counseling as in intern in 1998 and have been licensed in the state of Texas since 2001. I have worked in both private practice and in school settings and have several years of experience with individuals, couples, adolescents, and adults. I am also a board-approved Supervisor for both LPC and LMFT.

Fees and Cancellation Policy:

Initial session fee of $125 and subsequent session fee of $115 per 55 min. session will be billed to you or to your insurance company. All charges are due at the time of the visit. Private Pay clients who are not using insurance may be given a discount on fees. **If you will not be able to keep an appointment, you must notify me 48 hours in advance or you will be responsible for paying for the session you missed**. In the case of contracted insurance agreements, missed appointments are not subject to any contracts and you will be responsible for the payment of the missed appointment(s). Phone sessions are also available as needed and charged in 30-minute increments. Copies of records will be processed for a fee of $50.00. If you request therapist to consult with another professional (attorney, physician, psychiatrist, etc.) a fee of $125 per hour will be assessed.

A $1,500 non-refundable retainer fee is due if therapist is subpoenaed or involved in court proceedings. This same fee will also be charged for each day the therapist spends on stand-by or in court.

Acceptable forms of payment for all services are cash, check or credit card. Checks will be processed as automatic/electronic checks unless otherwise noted. Account information (electronic check and/or credit card number) will be kept on file and used to bill session fees, deductibles, co-pays, missed appointment fees, and any other balances owed to the therapist. Receipts will be emailed or mailed to you for your records.

If your balance becomes 30 days past due, services will not be scheduled, except in the case of an emergency, until the balance is paid in full.

Records and Confidentiality:

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your/client's privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This form is an agreement between you, the client, and this clinic. When we use the word "you" below, it refers to your child, relative, or you as a client. When we examine, diagnose, treat or refer you, we will be collecting what the laws call Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share your information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

All our communication becomes part of the clinical record, which is accessible to you upon request. Please be aware that the therapist may choose not to release these records if they could be emotionally or legally damaging to the client. The therapist will make these records available to another mental or medical health professional at the client's request. In the case of a minor, request may be made by a parent or legal guardian only.

I will keep confident anything you say to me, with the following required exceptions:

(a) you reveal to me any incidence of child or elder abuse
(b) I determine that you are a danger to yourself or others
(c) I am ordered by a court of law to disclose information
(d) I am required to use the data to defend myself in a complaint, lawsuit or claim.

By signing this form, you are agreeing to let us use your information here and send it to others, such as insurance companies or other providers that we might need to refer you to. You have the right to ask us in writing not to use or share your information. Although we will try to respect your wishes, we are not required to agree to these limitations.
There is a vulnerable aspect in electronic communication such as faxes, emails, cell phone texts/calls, etc. that may not be preventable regardless of all safeguards.

Counseling of Minors:
I am committed to providing confidentiality for minor clients to provide the most therapeutic experience. However, I will provide generalized information about the therapy sessions to the parents/guardians of the client, as I feel necessary and helpful. Parents of minors in therapy are involved in the process and will participate in formulating and carrying out treatment goals. Consent for treatment of minors must be signed by the parent or guardian with the legal authority to do so and all fees must be paid by the consenting parent regardless of your legal agreement. In the case of divorced parents, please provide a copy of custody agreement within one week of the first counseling session. Receipts will be provided for you if you are needing to seek reimbursement from the other parent. However, I will not intervene in any dispute of financial responsibility dispute between the consenting parent and another party.

By signing below, I consent to treatment with Janet A. Harrison, LPC-S, LMFT-S of Stone Oak Counseling. I acknowledge that I have read and understand the informed consent and the HIPAA Notice of Privacy Practices, and that any questions I had have been answered to my satisfaction. In addition, I understand that while there are other practitioners in this office, Janet A. Harrison LPC-S, LMFT-S and Stone Oak Counseling is a private practice counseling center and is NOT associated with any other practitioner at this location and is NOT a part of any group practice.

_____ _____
Client's Signature or Minor's Parent/Guardian Signature Date

_____ _____
Counselor's Signature Date