Client Information Sheet

Date: _____

Client Name: _____ Birth Date/Place: _____

Sex: _____ Race: _____ Religion: _____ Age: _____

Adult Clients

Relationship Status: _____

Spouse or Significant Other: _____ Age: _____ Time Together: _____

Children and Ages: _____

Highest Grade/Degree: _____ Type of Degree: _____

Child/Adolescent Clients

Grade: _____ School: _____ Child Resides With: _____

Custody or Visitation Schedule: _____

Parent/Guardian Name(s): _____

Relationship Status: _____ Time Together: _____

Highest Grade/Degree: _____ Type of Degree: _____

Contact Information

Primary Physical Address: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____ May I text you? yes/no

Email Address: _____ May I email you? yes/no

Employer: _____ Work Phone: _____

Emergency Contact

Emergency Contact: _____ Contact Phone: _____

Relationship to Client: _____

Insurance Information

Insurance Company: _____ Insured's Employer: _____

Primary Insured's Name: _____ Relation to Client: _____

Primary Insured's DOB: _____ /_____ / _____

Insurance ID Number: _____ Group Number: _____

Referred by: _____

Carla S. Schnitz, M. Ed., LPC 704 B 5th Street, Marble Falls, TX 78654 P: 210.823.4202 F: 830.798.1639
carlaschnitz@gmail.com

Informed Consent

Thank you for choosing my practice for counseling services. This informational document will cover many important topics regarding the services you are pursuing. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, state and federal laws, and your rights. I encourage you to ask any questions you have about my way of working or counseling in general at any point in our journey together.

Purpose and Goals of Counseling

The purpose of counseling is to help people use their existing problem-solving skills more effectively and/or to develop new or better coping abilities. There can be many goals for the counseling relationship. Some of these will be long term goals such as improving the quality of your life, learning to live with mindfulness, and self-actualization. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, or changing or decreasing unwanted behaviors. Whatever the goals, they will be set by the clients according to what they want to work on in counseling. The counselor may make suggestions on how to reach that goal but you decide where you want to go.

Qualifications

I am licensed by the Texas Board of Examiners of Professional Counselors. I have a Bachelor of Arts degree in Psychology from Texas A&M in College Station, Texas. I hold a Masters in School Counseling from Lamar University in Beaumont, Texas. If our work together indicates that there are issues beyond my personal expertise, I will refer you to an appropriate practitioner that may better provide necessary services. If you feel that I have violated my professional responsibilities, I ask that you communicate your concern with me first. You may also report your complaint to the Texas State Board of Examiners of Professional Counselors at 512.834.6658.

Arrangement of Services

It is hoped that you will be better able to understand your situation and feelings and move toward resolving your problems. Although no one can solve problems for you, I will use my knowledge of human development and behavior to make observations about your situation and offer suggestions for new ways to problem solve. It is my responsibility to listen, understand, and be helpful to the fullest extent of my professional ability. It is your responsibility to help me understand your life situation, thoughts, feelings, and to have the courage to try new approaches in order for change to occur. It is important that you share with me the goals you have for therapy and realize that entering therapy does not always guarantee anticipated outcomes.

Our first 2-4 sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and suggest a treatment plan that will help you reach your goals. It is important for you to carefully consider this information. In order for counseling services to be most successful, you will have to actively work on things we talk about both during our sessions and at home.

Appointments will ordinarily be 45-50 minutes in duration once per week, although some sessions may be more or less frequent as needed. Once an appointment hour is scheduled, you will be expected to pay for the session unless you provide 24 hours advance notice of cancellation or unless we both agree that you were unable to attend due to circumstances beyond your control. In addition, you are

responsible for coming to your session on time; if you are late, your appointment will still need to end at the designated time as a courtesy to other clients. I am also expected to be on time and will make appropriate remedy if I am late, such as by making up the time, prorating the fee, etc.

Implications

Counseling is an intensely personal process which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Clients can sometimes make improvements only to go backwards after time. Progress may happen slowly. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

There are many benefits to counseling as well. Counseling can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, and learn to live in the present.

Fees

Before sessions are scheduled, payment arrangements will be made. Initial evaluations are $150, with subsequent sessions are $100/hr. Payment in full is due at the time services are rendered, unless you make special arrangements with me beforehand. Because I respect the integrity of therapy sessions, fees must be paid at the beginning of the appointment time. When payment is collected at the end, it can disrupt the momentum of the session. After hours calls, emergencies, or outside of the office therapy will be billed at the rate of your regular fees. This includes phone calls of over five minutes, and travel time. If you urgently require assistance please call your local '911' operator or go directly to the nearest Emergency Clinic.

Confidentiality

I will make every effort to keep your personal information private. In general, the privacy of all communications between a client and counselor is protected by law, and I can only release information about our work to others with your written permission; however, there are limited exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment, yet in proceedings in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are also some situations in which I am legally obligated to take action to protect you or others from harm, even if I have to reveal some information about your treatment. Instances like this include abuse of a child, a disabled person, or an elderly person. Additionally I am required to take protective actions if I believe you pose a threat to yourself or others. These actions may include notifying the potential victim and/or contacting the police. Please know that in the event such an instance occurs, I will make every effort to fully discuss it with you before taking any action.

Sometimes I find it helpful to consult with other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential.

Client's Rights

I will keep records of our counseling sessions and treatment plans in order to ensure direction and continuity during our time together. They will not be shared except with respect to the limits of confidentiality discussed in the Confidentiality section. Should you wish to have your records released,

you are required to sign a release of information which specifies what information is to be released and to whom.

You are entitled to receive a copy of your records, or I can prepare a summary for you. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Please understand that you will be charged an appropriate fee for any professional time spent in responding to information requests.

At any time you may question and/or refuse therapeutic or diagnostic procedures. The choice to follow through with recommendations is yours; however, I reserve the right to discontinue counseling if the choice not to follow recommendations and /or the lack of cooperative progress is considered harmful to you. Professional ethics mandate that treatment continues only if it is reasonably clear that you are receiving benefit. If appropriate, referrals to other therapists will be provided and you will be asked to attend a final termination session.

Method of Contact

I often am not available immediately by telephone. I rarely answer my phone when I am with other clients. At these times, you may leave a message on my confidential voice mail which I monitor frequently. I will make every effort to return your call on the same day, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you are available. If you feel you cannot wait for a return call or it is an emergency situation, go to your local hospital or call 911. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact if necessary.

Informed Consent to Treat *Please initial and sign below:*

_____ *When you sign this document, it will represent an agreement between us. Your signature indicates that you have read the information in the Informed Consent document and agree to abide by its terms during our professional relationship.*

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), Carla Schnitz, LPC maintains compliance with all Safety and Security Rules and will not release or share any information without following the specified guidelines and procedures.

Client Name: _____

Client or Legal Guardian Signature: _____ Date: _____

Address: _____

Counselor Signature: _____ Date: _____

Financial Agreement Form

Client Name: _____ Parent/Guardian: _____

Please initial each section if in agreement:

_____ It is agreed upon that the above named client or client's guardian has discussed with Carla S. Schnitz, the following identified payment arrangements as the fee(s) for the service of Professional Counseling and related administrative services, and agrees to the payment of those fees. It is also agreed and understood that certain insurance, health coverage, or contracted agreements maintain a fee schedule with managed rates and require the direct billing for reimbursement of related costs. As the client/guardian, I hereby authorize Carla S. Schnitz, of Carla Schnitz Counseling Services, to direct bill for the reimbursement of these costs.

_____ I realize that certain information pertaining to the purpose and process of professional counseling and some privileged records may be necessarily released for utilization review and insurance billing. I hereby authorize the release of such information or records necessary for the reimbursement of counseling services received.

_____ I further realize that third party payment for services is never guaranteed and that significant efforts will be made to appropriately and legally receive payment for charges. I accept full financial responsibility for all charges including any balance not paid by insurance. I also agree to be responsible for any expenses including attorney's fees or collection agency fees, incurred in order to recover the monies owed for said services and otherwise enforce any default by me under this agreement. Full payment must be received no later than 90 days from the date of service. If a client pays the cost of any service provided and later payment is received from a third party, any overage of payment will be refunded to the client immediately.

Insurance Company Name: _____ Insured's Name: _____

Billing Rate per Therapy Hour: $_____ Contracted/Insurance Rate OR $_____ Self Pay/$_____ per hour

Client or Legal Guardian Signature: _____ Date: _____

Carla S. Schnitz, M.Ed., LPC: _____ Date: _____

Carla S. Schnitz, M. Ed., LPC 704 B 5th Street, Marble Falls, TX 78654 P: 210.823.4202 F: 830.798.1639
carlaschnitz@gmail.com

Release of Information & Consent Form

Client Name: _____ Parent/Guardian: _____

Date of Birth: _____ / _____ / _____ Address: _____

Phone: _____

I, _____, hereby authorize the release and exchange of information specified below between:

_____

Name/Title of Organization Name (i.e., Psychiatrist, Primary Care Physician, or entity)

_____

Organization Address

_____

Phone/Fax

And:
Carla S. Schnitz, M.Ed., LPC
704 B. 5th Street
Marble Falls, Texas 78654
P: 210.823.4202 F: 830.798.1639

This release of information shall be limited to the following specific types of information:

_____ Assessment
_____ Psychosocial Evaluation
_____ Treatment Plan or Summary
_____ Diagnosis
_____ Progress in Treatment
_____ Participation in Treatment
_____ Current Treatment Update
_____ Continuing Care Plan
_____ Other: _____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, and when appropriate, coordinate treatment services. If other purposes, please specify: _____

This authorization for release of information is made with informed consent, and this consent is subject to revocation by written instructions of the undersigned at any time by sending notification to Carla S. Schnitz, LPC. However, revocation is not valid to the extent that parties have acted in reliance on such authorization. The information is confidential and any redisclosure by the recipient is prohibited, unless expressly permitted by the client or someone authorized to act on his/her behalf. I understand that this authorization authorizes the release of all medical records including psychiatric, Alcohol, and Drug Abuse.

Printed Client Name: _____

Client Signature: _____ Date: _____

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by:

_____

Printed Name: Patient or Responsible Party

_____

Patient Signature or Responsible Party Date

_____

Relationship to patient (if other than patient)

Witness:

_____

Printed Name-Practice Representative

_____

Signature Date

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