Richland Oaks
Counseling
Center

1221 Abrams Road
Suite 325, Box 17
Richardson, TX 75081

P: 469-619-ROCC (7622)
F: 469-458-7024
E: RichlandOaks@gmail.com
W: www.richlandoaks.org

THERAPY INTAKE PACKET (Adult)

Included in this Packet:

(1) Information & Consent Form (pp. 2-4)
(2) Intake Questionnaire (pp. 5-13)
(3) Notice of Privacy Practices (pp. 14-15)
(4) Acknowledgment of Receipt of NPP (p. 16)
(5) Group Interest Survey (p. 17)
(6) Credit Card Authorization Form (p. 18)

Instructions:

Before your Appointment:

(1) Read and Sign/Date the ***Office Copy*** of the **Information & Consent Form**
(Keep the *Client Copy* that is printed for you)
(2) Complete the **Intake Questionnaire**
(3) Review the **Notice of Privacy Practices (NPP)**
(4) Sign/Date the **Acknowledgment of Receipt of NPP**

Bring to your Appointment:

(1) The signed *ROCC Copy* of the **Information & Consent Form**
(2) Your completed **Intake Questionnaire**
(3) The signed **Acknowledgment of Receipt of NPP**

If you have any questions regarding these forms, please call (469) 619-7622.

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Information and Consent Form

[Client Copy – Keep for your records]

Services Provided

Richland Oaks Counseling Center (ROCC) offers a variety of individual, couples, and group therapy services provided by psychologists, counselors, psychology post-doctoral and pre-doctoral interns, and psychology and counseling graduate students.

Psychotherapy

Psychotherapy can have both risks and benefits. The therapy process may include discussions of your personal challenges and difficulties which can elicit uncomfortable feelings such as sadness, guilt, anger and frustration. However, psychotherapy has also been shown to have many benefits. It can often lead to better interpersonal relationships, improved academic performance, solutions to specific problems and reduction in your feelings of distress. But, there is no assurance of these benefits

Confidentiality

In keeping with professional ethical standards and state and federal law, all services provided by the staff of ROCC are kept confidential except as noted below and in the accompanying *Notice of Privacy Practices*. We consult as needed within the staff of ROCC about the best way to provide the assistance that you might need. As required by psychological practice guidelines and current standards of care, we keep records of all therapy sessions. These records are stored securely consistent with federal and professional security standards for medical records.

ROCC professional staff have a legal responsibility to disclose client information without prior consent when a client is likely to harm himself, herself or others unless protective measures are taken, when there is reasonable suspicion of abuse of children, dependent adults or the elderly, when the client lacks the capacity to care for him or herself and when there is a valid court order for the disclosure of client files. Fortunately these situations are infrequent.

By signing this form you also give ROCC permission to communicate with the Emergency Contact that you have designated if we believe that you are at risk. If you are suing someone or being sued, or if you are charged with a crime and you tell the court that you are a client at ROCC, ROCC or your clinician may then be ordered to show the court your records. Please consult your lawyer about these issues.

Please consult with your clinician if you have any questions about confidentiality.

Policies

ROCC is not an emergency or crisis intervention facility. Clinicians are not available 24 hours per day; however, you can always leave a message at ROCC (469-619-7622) and the Office Manager will have your clinician contact you as soon as possible. In the event of an emergency or crisis between scheduled appointments, go to the nearest emergency room or seek help by the Suicide Crisis Center 24-Hour Line at 214-828-1000 (all ages), or call 911 if it is a life-threatening situation.

Your initial session is an assessment session, devoted to gathering information about you, your current difficulties, and biographical information that will assist your clinician in developing a treatment plan and interventions that are specific to you. If at any point it is determined that other services are more suitable or would be beneficial in

addition to your treatment at ROCC, we will help you obtain assistance from appropriate providers. Noncompliance with treatment could result in the termination of services.

Please arrive on time for your appointments. If you are unable to keep your appointment, please call to cancel at least 24 hours in advance. If you miss or cancel an appointment without giving 24 hours' notice, you will be required to pay a fee for the missed appointment according to the time that was scheduled. Repeated cancellations or missed appointments may result in the termination of services.

Our goal is to provide the most effective psychotherapeutic experience. If you feel that your clinician is not a good match for you, we encourage you to discuss this matter with your current clinician. Alternatively, you can speak with the Clinical Director of ROCC. Either of the above may explore a shift in approach or facilitate a transfer to a different clinician, if necessary. If you have questions or comments about our services, please ask at your initial appointment, complete a Client Experiences Survey (CES) or arrange to speak with our director.

In general, you may review your records in ROCC's files at any time. There are some limitations regarding raw testing data, but for the most part, you have access to your information. You may add to this information or correct this information, and you may have copies of the records. However, you may not examine records created by anyone else and sent to ROCC.

Psychiatric Consults and Medication
ROCC does not retain a psychiatrist on staff, nor do we prescribe or dispense psychiatric medications. ROCC can provide you with a psychiatric referral if deemed necessary. You may sign a release to enable ROCC to consult with your Psychiatrist.

Use of Electronic Mail
Please be aware that e-mail may not be private or confidential and may not be read by the recipient in a timely fashion.

ROCC is a Training and Research Site for Psychologists and Counselors
ROCC is a training and research facility. Thus, the treatment you receive may be conducted in full or in part by a qualified graduate counseling or clinical psychology student, psychology pre-doctoral intern or post-doctoral fellow, licensed professional counselor or licensed psychologist. All clinicians in training will inform you of their trainee status as well as the name of their supervising counselor or psychologist who can be contacted through our office. In order to adequately supervise trainees, a supervisor may ask that sessions be audio or video recorded. Supervisors may also wish to record therapy sessions for training purposes, but will ask your permission to do so. All recordings are kept confidential in the same manner as your treatment records and will be erased after supervisory review. You may choose not to have your sessions recorded. Please talk with your clinician if you have questions about audio and video recording.

ROCC utilizes psychological test data in archival research and the training of graduate students in mental health. Archival research is the study of past psychological test scores from your records to investigate scientific questions that arise in the future. This scientific investigation is generally aimed at improving treatment outcomes and increase our understanding of psychiatric conditions. This data will be collected, scored without you or your name being identified and without any personal information from which you may be identified. By signing this form you agree to allow the use of this data for research with the understanding that you will receive no financial benefit from the use of the archival data.

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Consent

By signing, I agree to be treated by a qualified ROCC clinician. I understand I have the right **not** to sign this form. My signature indicates I have read and discussed this agreement; it **does not** indicate that I am waiving any of my rights. I understand that I can choose to discuss my concerns with the clinician before I begin treatment. I understand that after my treatment begins I have the right to withdraw my consent at any time, for any reason. However, I will make every effort to discuss my concerns with the clinician before ending my treatment.

Please sign below to indicate that you understand and agree to participation in psychotherapy at Richland Oaks Counseling Center (ROCC) in accord with the policies outlined above.

Confidentiality and Exceptions to Confidentiality

Therapy comes with an assumption that what is said by you is kept confidential by your therapist. Certain laws and prudent professional practice affect your therapist's choice to keep your information completely confidential. Please read the following carefully, discuss all concerns and questions with your therapist, and initial as appropriate. The following is not intended to be a guarantee that other circumstances will not arise which may impact confidentiality. You deserve to have exceptions to confidentiality discussed with you, but your legal rights are affected by outside influences, such as changes in the law.

- I, _____, understand that, if I am in imminent danger of harming myself or others:
  - _____My therapist may notify medical or law enforcement personnel without my permission.
  - _____I give my therapist permission to also notify the following person(s):

Name: _____
Address: _____
Telephone: _____
Relation: _____

  - _____I understand that my therapist is required by law to report suspected child or elder abuse (65)
  - _____I understand that the use of third party payment resources often require reporting by my therapist of otherwise confidential information, such as diagnosis of a mental health disorder.

_____ _____
Signature of Client or Client's Representative Date

_____
Print Name

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Intake Questionnaire

Today's date: _____/_____/_____
month day year

First Name: _____ MI: _____

Last Name: _____

Birth date: _____/_____/_____ Current Age: _____
month day year

Contact Information:

Street Address _____

City _____ Zip _____

Cell Phone # _____

☐OK to phone ☐OK to leave message

Home or other phone # _____

☐OK to phone ☐OK to leave message

Preferred E-mail address: (Please be aware that email might not be confidential.)

_____

☐ OK to email regarding your appointment

☐ OK to email an evaluation survey regarding your experiences with ROCC

Preferred Method of Contact:

☐Cell Phone ☐Home Phone ☐Email ☐Mail

☐Other (specify) _____

Emergency Contact:

Name _____

Relationship to you _____ Phone _____

Address _____

SECTION A: Demographic Information

(A1) Gender:

☐ Female ☐ Male ☐ Transgender ☐ Other _____

(A2) Ethnicity:

☐African☐ Black / African-American

☐Puerto Rican☐Chinese / Chinese-American

☐East Indian / Pakistani☐Filipino

☐ Indian☐Japanese / Japanese-American

☐Korean / Korean-American ☐Latino / Latino-American / Hispanic

☐ Mexican / Mexican-American☐Middle Eastern

☐Native-American / Alaskan Native☐Polynesian / Micronesian

☐Vietnamese / Vietnamese-American ☐White / Caucasian

☐Other (specify) _____☐Prefer Not to Answer

☐Multiracial/Multiethnic (specify) _____

(A3) Sexual Orientation:

☐Bisexual ☐Heterosexual ☐Lesbian/Gay ☐Questioning

Other (specify) _____

(A4) Relationship Status:

☐Single ☐Partnered ☐Married ☐Separated

☐Divorced☐Widowed ☐Other (specify) _____

If applicable, please list your current or former partner or spouse's age and occupation:

_____

If applicable, how long have you / were you in this relationship_____

(A5) Educational Information: (check highest degree you have earned)

☐GED☐High School☐Associates Degree☐Bachelor's Degree

☐Master's Degree ☐Doctoral Degree

Schools Attended/Attending _____

_____

Field(s) of study _____

(A6) Occupational Information:

Are you currently employed? ☐Yes ☐No

If yes, list your current occupation and employer below. If no, list your previous occupation and employer below.

Occupation _____

Employer _____

(A7) Military Service:

Are you a Veteran? ☐ Yes ☐ No

If yes, what branch of military _____ Time of Service: _____

(A8) Referred By: (check all that apply)

☐ Self (see below) ☐ Friend☐ Family Member☐ School

☐ Disability Services ☐ Medical Provider ☐ Clergy / Religious Leader

☐ Other (specify) _____

If Self, how did you hear about our services? ☐ROCC Website

☐ Other Website☐ Brochure☐ Presentation / Lecture / Workshop

☐ Other (specify) _____

SECTION B: Presenting Concerns

(B1) Briefly describe what brings you to Richland Oaks Counseling Center (ROCC): _____

_____

_____

_____

_____

_____

(B2) Approximately how long have these concerns been bothering you?

☐ Day☐ Week☐Month☐ Several months☐ Year

☐ Several years☐ Most of my life

(B3) How much do these concerns interfere with your:

Daily Routine: Very little : 1 2 3 4 5 : Severe

Emotional Well-being: Very little : 1 2 3 4 5 : Severe

Relationships/Activities: Very little : 1 2 3 4 5 : Severe

Work / School: Very little : 1 2 3 4 5 : Severe

SECTION C: Health History

(C1) Physician Information:(list name, address and phone number)

Primary Care Physician _____

_____

Psychiatrist _____

_____

Other _____

(C2) When was your last physical exam? _____

(C3) Currently, how is your physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

(C4) Have you had any serious accidents or injuries? ☐ Yes (specify below) ☐ No

If yes, please describe: _____

_____

_____

_____

_____

(C5) Check any of the following symptoms that you have had, including dates as best you can:

☐ Asthma _____ ☐ Heart problems _____

☐ Chest problems _____ ☐ HIV+ / AIDS _____

☐ Cancer _____ ☐ Joint / limb problems _____

☐ Chicken pox _____ ☐ Liver / kidney problems _____

☐ Dental problems _____ ☐ Other neurological problems _____

☐ Ear, nose or throat problems _____ ☐ Rheumatic fever / strep infections _____

☐ Growth / endocrine problems _____ ☐ Seizures / convulsions _____

☐ Gynecological / menstrual problems _____ ☐ Serious accidents / fractures _____

☐ Head injury / loss of consciousness _____ ☐ Skin problems _____

☐ Hearing / vision problems _____ ☐ Stomach or bowel problems / soiling _____

☐ Hepatitis _____ ☐ Urinary or bladder problems / wetting _____

(C6) Please list any other persistent physical symptoms or health concerns: (e.g., chronic pain, headaches, hypertension, diabetes, etc.) _____

_____

(C7) Do you regularly take any prescribed medications, over-the-counter drugs, supplements or alternative remedies to treat a medical condition? ☐ Yes ☐ No

If yes, please list any medications you are currently taking, the condition for which the medication is taken, and the prescribing physician (if applicable):

(e.g., Prevacid30 mg, stomach ulcer, Family Doctor)

_____

_____

(C8) Are you having any problem with your sleep habits? ☐No problems ☐Sleeping too much

☐Sleeping too little ☐Poor quality of sleep ☐Disturbing dreams

☐Other (please describe) _____

(C9) How many times per week do you exercise?

☐ One or less ☐ Two to four ☐ Five or more

For about how long do you exercise at a time? _____

(C10) Are you currently having difficulty with appetite or eating habits? Check all that apply.

☐ No difficulty ☐ Eating less ☐ Eating more ☐ Binging

☐ Restricting ☐ Significant weight change (gain or loss)

Please describe the nature of your eating habits or weight change: (e.g., frequency of eating patterns, how much weight lost and time frame, etc.) _____

_____

_____

(C11) Do you have any problems or worries about sexual functioning? Check all that apply.

☐ No concerns ☐ Lack of desire ☐ Performance problem

☐ Sexual impulsiveness ☐ Difficulty maintaining arousal

☐ Worried about sexually transmitted disease

☐ Other (specify): _____

SECTION D: Mental Health History

(D1) Have you received counseling or psychotherapy in the past?

☐ Yes (specify below) ☐ No

If yes, please explain, including when and with whom. _____

_____

_____

_____

_____

(D2) Are you a returning client to Richland Oaks Counseling Center (ROCC)?

☐ Yes (specify below) ☐ No

If yes, when did you receive services at ROCC, and who was the mental health provider/clinician:

(e.g., Fall 2011, Dr. Leach) _____

(D3) Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere? ☐ Yes (specify below) ☐ No

If yes, please provide the mental health provider's name and phone number:

(e.g., Dr. Smith, 214-555-5555) _____

(You must complete a release of information form if you choose to have ROCC share information with this provider.)

(D4) Have you been diagnosed (currently or in the past) as having a psychiatric disorder? (e.g., anxiety disorder, mood disorder, learning disorder, post-traumatic stress disorder, eating disorder, personality disorder, etc.)

☐ Yes (specify below) ☐ No

If yes, please list the disorder(s) and approximately when the diagnosis was made:

_____

_____

_____

_____

(D5) Have you been prescribed psychiatric mediation in the past?

☐ Yes (specify below) ☐ No

If yes, please list what medications, dosage, and when taken:

(e.g., Prozac, 20 mg, 2008-2010) _____

_____

_____

Were the medications helpful? ☐ Yes☐ No

(D6) Are you currently taking prescribed psychiatric medication, antidepressants, or other medications? ☐ Yes (specify below)☐ No

If yes, please list any psychiatric medications you are currently taking and the prescribing psychiatrist/physician: (e.g., Prozac, 20 mg, Family Doctor)

_____

_____

_____

_____

_____

_____

_____

Are the medications helpful? ☐ Yes ☐ No

(D7) Have you been hospitalized for psychiatric reasons?

☐ Yes (specify below) ☐ No

If yes, please specify reason for past hospitalization: (check all that apply)

☐Psychological problems ☐ Suicide thoughts / attempt

☐Dangerousness to others ☐ Drug / Alcohol

☐ Other (specify) _____

Was the hospitalization helpful? ☐ Yes☐ No

SECTION E: Family and Social Information

(E1) Please list the members of your family (e.g., parents, siblings, relatives with whom you are close; *list children in Question F2*): (e.g., Bob, father, living, 58, accountant)

Name, Relationship to you, Living or Deceased Age (or age at time of death), Occupation

_____

_____

_____

_____

_____

_____

_____

_____

_____

(E2) Do you have children? ☐ Yes ☐ No

If yes, please list name, age and gender of children (indicate if step, foster or adopted child):

(e.g., Tommy, male, living, 9, 3rd grade, biological)

Name, Gender, Living or Deceased, Age/Grade, Biological/step/foster/adopted child

_____

_____

_____

_____

_____

_____

If yes, do you have full custody of your children? ☐ Yes ☐ No (specify below)

If no, describe the custody arrangement _____

_____

(E3) Besides family members, approximately how many people can you count on right now for friendship and emotional support? _____

_____

(E5) Is there any additional information about you, your current difficulties, special circumstances or challenges within your family, relationships, or educational or work environment that would be helpful for us to know? _____

_____

_____

_____

_____

_____

_____

_____

Thank you for completing the Intake Questionnaire.

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Notice of Privacy Practices (NPP)

[Client Copy – Retain for your records]

This notice describes how mental health information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully.

Richland Oaks Counseling Center is a teaching and research clinic. Graduate counseling and clinical psychology students, pre-doctoral interns, and post-doctoral fellows may participate in your care as a part of their mental health training programs. All care is overseen and supervised by a licensed mental health professional. All information describing your mental health treatment and related health care services ("mental health information") is personal, and we are committed to protecting the privacy of the personal and mental health information you disclose to us. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. When we disclose information to other persons and companies to perform services for us, we require them to protect your privacy, too. This Notice also applies to your psychologist, counselor, psychiatrist and other health care professionals who provide care to you. We must also provide certain protections for information related to your medical diagnosis and treatment, including HIV/AIDs, and information about alcohol and other substance abuse. We are required to give you this Notice about our privacy practices, your rights and our legal responsibilities.

WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION:

- For Treatment. For example, we may give information about your psychological condition or assessment to other health care providers, such as your family physician or another psychologist, to facilitate your treatment, referrals or consultations.
- For Payment. For example, a health care provider may contact your insurer to verify what benefits you are eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.
- For Healthcare Operations For example, we may give information to University or professional mental health and training organizations to review the quality of care provided, for performance improvement or for the training of health professionals. Other examples could include audits and administrative services, and case management and care coordination.
- For Appointments and Services to remind you of an appointment, or tell you about treatment alternatives or health related benefits or services.
- To Individuals Involved in Your Care. For example, your parents, if you are a minor, or your conservator.
- With your written authorization we *m*ay use or disclose mental health information for purposes not described in this Notice.

WE MAY USE YOUR MENTAL HEALTHINFORMATION FOR OTHER PURPOSESWITHOUT YOUR WRITTEN AUTHORIZATION:

- As Required by Law when required or authorized by other laws, such as the reporting of child abuse, elder abuse, disabled or dependent adult abuse.
- For health oversight activities to governmental, licensing, auditing, and accrediting agencies as authorized or required by law including audits; civil, administrative or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.

- In Judicial Proceedings in response to court/administrative orders, subpoenas, discovery requests or other legal process. If ROCC and/or your clinician is subpoenaed to appear in court and provide testimony regarding our knowledge and experience of you and our assessment, we will assert privilege on your behalf. Nevertheless, if the judge insists we testify, we will testify truthfully and honestly to our thoughts and professional opinion.
- To Public Health Authorities to prevent or control communicable disease, injury or disability, or ensure the safety of drugs and medical devices.
- To Law Enforcement for example, to assist in an involuntary hospitalization process.
- To the State Legislative Senate or Assembly Rules Committees for legislative investigations.
- For Research Purposes subject to a special review process, and the confidentiality requirements of state and federal law.
- To Prevent a Serious Threat to Health or Safety of an individual. We may notify the person, tell someone who could prevent the harm, or tell law enforcement officials.
- To Protect Certain Elective Officers including the President, by notifying law enforcement officers of potential harm.

YOU HAVE THE FOLLOWING RIGHTS:

- To Receive a Copy of this Notice when you obtain care.
- To Request Restrictions. You have the right to request a restriction or limitation on the mental health information we disclose about you for treatment, payment or health care operations. You must put your request in writing. We are not required to agree with your request. If we do agree with the request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment.
- To Inspect and Request a Copy of your Mental Health Record except in limited circumstances. A fee will be charged to copy your record. You must put your request for a copy of your records in writing. If you are denied access to your mental health record for certain reasons, we will tell you why and what your rights are to challenge that denial.
- To Request an Amendment and/or Addendum to your Mental Health Record**.** If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record) of no longer than 250 words for each inaccuracy. Your request for amendment and/or addendum must be in writing and give a reason for the request. We may deny your requestor an amendment if the information was not created by us, is not a part of the information which you would be permitted to inspect and copy, or if the information is already accurate and complete. Even if we accept your request, we do not delete any information already in your records.
- To Receive an Accounting of Certain Disclosures we have made of your mental health information. You must put your request for an accounting in writing.
- To Request That We Contact You By Alternate Means (e.g., fax versus mail) or at alternate locations. Your request must be in writing, and we must honor reasonable requests.

CHANGES TO THIS NOTICE: Richland Oaks Counseling Center reserves the right to change or revise this Notice. If a revision is made to our policies and procedures, a revised copy will be posted in the office and a copy will be provided to you upon request.

CONTACT INFORMATION: If you have any questions about this Notice, please contact the office manager at Richland Oaks Counseling Center, 1221 Abrams Road, Suite 325, Richardson, Texas, 75081, or by telephone at 469-619-7622.If you believe your privacy rights have been violated, you may contact the Texas Board of Examiners of Psychologists at 1-800-821-3205. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. **You will not be penalized for filing a complaint.**

Effective Date: May 1, 2012

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Acknowledgment of Notice of Privacy Practices
[ROCC Office Copy]

The Richland Oaks Counseling Center Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we will provide you, copies of the current notice may be obtained through the office manager at ROCC.

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____
Signature of Client or Client's Representative *Date*

_____
Print Name

Interpreter (if applicable) _____*Relationship to Client* _____

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Group Interest Survey

Richland Oaks Counseling Center is constantly looking for ways to provide accessible psychological services to the community. Please take a moment and fill out the survey to help us determine the needs and interest of the community.

1. Please check the box next to a group you may be interested in attending (Check all that apply).
   - DBT Skills Group
   - Parenting Skills Group
   - Social Skills Training Group (Adults)
   - Social Skills Training Group (Children)
   - Professional Women's Group
   - Relationship Issues Group
   - Couples Therapy and Communication Group
   - Autism Spectrum Group (Adults)
   - Men's Life Transition Group
   - Psychology in Poetry Group
   - Video Game Addiction Group
   - Divorce Recovery Group
   - Life Transitions Group
   - Adolescent Boy's Group
   - Parenting the Love and Logic Way
2. Would you like to be contacted if the group you selected becomes available?
   - Yes
   - No

Name: _____
Phone Number: _____

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Credit Card Authorization Form

PLEASE PRINT OUT AND COMPLETE THIS AUTHORIZATION AND RETURN TO US.
All information will remain confidential.

Card Holder Name: _____
Billing Address: _____
_____

Credit Card Number: _____
Expiration Date: _____ Security Code (3-digit):_____

Amount to Charge: $ _____ (USD) I authorize _____ to charge the agreed amount listed above to my credit card provided herein. I agree that _____ may charge a $_____ fee for missed or canceled appointments without 24 hour notice. I agree that I will pay for this service in accordance with the issuing bank cardholder agreement.

Cardholder- Print Name, Sign and Date Below:
Signed: _____
Date: _____
Name: _____