



Cindy Oliphant, MA, LPC-S

A Professional Limited Liability Corporation

1022 Ridge Road

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CONFIDENTIAL CLIENT INTAKE INFORMATION

Date _____

Who referred you to my practice? Name _____

Address &/or _____

phone _____

May I have your permission to thank them for the referral? Yes ___ No ___

Section 1: CLIENT INFORMATION

Client Name or Parent _____ Spouse _____

Address _____ City _____ Zip _____

Phone: Home () _____ Work () _____

Cell () _____ e-mail _____

Date of Birth _____/_____/_____ Age ___ Soc. Sec. # _____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widow ___ Partner ___

Employer _____

Address _____

Child (IF CLIENT) : Names, Ages and Birthdates _____

***** IF ANY CHILDREN UNDER 18 WILL BE RECEIVING MY COUNSELING SERVICES, PLEASE FILL OUT: I _____ (Print your name), HAVE LEGAL CUSTODY AND GIVE MY CONSENT FOR COUNSELING OF THE ABOVE NAMED MINOR(S).**

SIGNATURE: _____

Have you been in counseling before? Yes ___ No ___ Name of Therapist _____

Reason: _____

Are you currently involved in any type of counseling? Yes _____ No _____

What type? _____ Name of Therapist _____

REASON YOU ARE SEEKING HELP NOW _____

MEDICAL DATA:

Physician _____ **Phone** _____

List Medications:

Section 2: INFORMATION ON THE INSURED (if not using insurance SKIP and go to Section 4)

NAME OF RESPONSIBLE PARTY _____ SS# _____

Client's relationship to the insured: Self _____ Spouse _____ Child _____ Other _____

Please complete the following ONLY if the insured IS NOT the client:

Insured's Name _____ Birthdate ___/___/___ SS# _____

Address _____ City _____ State _____ Zip _____

Phone: Home () _____ Work () _____ Cell () _____

Employer _____

Address _____ City _____ State _____ Zip _____

Section 3: INSURANCE POLICY INFORMATION

Insurance Company _____ Address _____

City _____ State _____ Zip _____

Plan Name _____ HMO _____ PPO _____ POS _____ EAP _____

Policy Number _____ Group Number _____

Authorization # _____ Covered by more than one insurance? _____

Phone number to verify Mental Health Coverage () _____

Section 4: EMERGENCY CONTACT

Name _____ Relationship _____

Phone _____

Address include City and State _____

Section 5: SPECIFIC PROBLEM AREAS

NOTE: If you are having thoughts of harming yourself or someone else, you should immediately go to the nearest emergency room or crisis center of your choice.

Please check any of the following that are currently troubling you:			
<input type="checkbox"/> Abortion	<input type="checkbox"/> Confusion	<input type="checkbox"/> In-laws	<input type="checkbox"/> Pornography
<input type="checkbox"/> Adoption	<input type="checkbox"/> Crisis / Conflict	<input type="checkbox"/> Job problems	<input type="checkbox"/> Use
<input type="checkbox"/> Addictions	<input type="checkbox"/> Death of loved	<input type="checkbox"/> Legal issues	<input type="checkbox"/> PMS/Hormones
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> one	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Religion or Faith
<input type="checkbox"/> Anger	<input type="checkbox"/> Depression	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Self-injury (i.e.,
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Divorce	<input type="checkbox"/> Loss of control	<input type="checkbox"/> cutting, burning)
<input type="checkbox"/> Apathy	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Loss of	<input type="checkbox"/> Separation
<input type="checkbox"/> Bitterness/	<input type="checkbox"/> Envy / Jealousy	<input type="checkbox"/> concentration	<input type="checkbox"/> Sexual
<input type="checkbox"/> Resentment	<input type="checkbox"/> Family issues	<input type="checkbox"/> Loss of energy	<input type="checkbox"/> abuse/Rape
<input type="checkbox"/> Burnout/Stress	<input type="checkbox"/> Fear	<input type="checkbox"/> Loss of memory	<input type="checkbox"/> Sexual addiction
<input type="checkbox"/> Burnout/Stress	<input type="checkbox"/> Finances/Debt	<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Sexual issues
<input type="checkbox"/> Change of	<input type="checkbox"/> Forgiveness	<input type="checkbox"/> Loss of temper	<input type="checkbox"/> Single parent
<input type="checkbox"/> lifestyle	<input type="checkbox"/> Frustration	<input type="checkbox"/> Loss of trust	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Child abuse	<input type="checkbox"/> Guilt	<input type="checkbox"/> Marriage	<input type="checkbox"/> Suicidal
<input type="checkbox"/> Children/	<input type="checkbox"/> Grief	<input type="checkbox"/> Medication/	<input type="checkbox"/> thoughts
<input type="checkbox"/> Discipline	<input type="checkbox"/> Growing older	<input type="checkbox"/> Drug Issues	<input type="checkbox"/> Self-esteem
<input type="checkbox"/> Children/	<input type="checkbox"/> Health/Medical	<input type="checkbox"/> Mid-life	<input type="checkbox"/> Rejection
<input type="checkbox"/> School issues	<input type="checkbox"/> Homosexuality	<input type="checkbox"/> Mother issues	<input type="checkbox"/> Violence/Rage
<input type="checkbox"/> Children/	<input type="checkbox"/> Honesty	<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Withdrawal
<input type="checkbox"/> Rebellion	<input type="checkbox"/> Infidelity	<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Worry

Other specific areas of concern:

Of the above, please list your top three areas of concern and how long these problem have existed:

Section 6: POLICIES AND PROCEDURES

APPOINTMENTS: Counseling sessions are fifty (50) minutes. Your appointment time is reserved exclusively for you. The standard and customary fee for a session is \$100.00. A missed appointment or no show with less than a 24-hour notice, unless due to illness or an emergency, will be charged the full fee price. A bill will be mailed directly to all clients who do not show up or cancel an appointment.

Payment for services is due at the time services are rendered and is the responsibility of the client or guarantor. Due to the wide variety of insurance policies and coverage, I cannot guarantee that your policy or your insurance company covers the services provided. The client and/or guarantor are ultimately responsible for payment since the services are provided to the client and not to his/her insurance company. Interest at the rate of 10% per month will be charged on balances outstanding more than 30 days. Returned checks are assessed a charge of \$25.00. Phone consultations are charged at a rate of \$25.00 per 15 minutes.

I understand that I am financially responsible for payment in full of all services rendered. I understand that if I fall behind in my financial responsibilities, Cindy Oliphant, LPC, PLLC, has the right to withhold further treatment until payment for prior services has been received.

Cindy Oliphant, LPC, PLLC, will notify me in writing of any amounts past due and give me thirty (30) days in which to make payment in full, or set up an agreeable repayment schedule. If I do not make payment in full or set up a repayment schedule, I give Cindy Oliphant, LPC, PLLC, permission to release information about me and my account (not clinical information) to any agency deemed appropriate for the collection of any past due amount.

Court Appearances: Clients will be responsible to pay up front, 100.00 per hour, plus expenses, for any court appearances, depositions or other legal matters, with a 2-hour minimum charge. Billable time will include the average drive time to and from 1022 Ridge Road, Rockwall, TX 75087 and the place of testimony.

Court/Insurance/or Documentation: Any requested or subpoenaed documentation on your behalf is provided at a charge of \$100.00 per hour. This does NOT include providing you with a standard receipt needed for insurance reimbursement purposes.

DUTY TO WARN: Confidentiality and privileged communication are rights of all clients according to United States and Texas law. However, some courts have held that if a client intends to take harmful or dangerous action against another human being or against him/herself, a counselor has a Duty to Warn: (a) The person who is likely to suffer the result of harmful behavior, (b) the family of the person who is likely to suffer the result of harmful behavior (c) the family of the client who intends to harm him/herself, or authorities and attempt to resolve the issue before the above actions are taken. (d) in cases of suspected child or elder abuse, the counselor has a responsibility to notify the appropriate authorities of such allegations. In addition, a court of law may, under circumstances, require the counselor to testify and/or release client files.

I HAVE READ, UNDERSTAND AND AGREE TO THE INFORMATION STATED ABOVE.

Signature of Client/Responsible Party

Date

AUTHORIZATIONS:

I authorize the release of any information necessary to process the above insurance claims and authorize payment of insurance benefits to CINDY OLIPHANT, LPC, PLLC.

I represent that I have legal authority to obtain counseling for any minor children treated.

I authorize Cindy Oliphant, LPC, PLLC, to perform any educational testing deemed appropriate for treatment upon my consent.

I authorize the release of any information necessary to coordinate treatment with medical professionals, therapists, hospitals, insurance or managed care companies, and/or schools involved with this case.

I HAVE READ THE ABOVE AND AGREE TO ABIDE BY THE POLICIES AND PROCEDURES OF CINDY OLIPHANT, LPC, PLLC, REGARDING APPOINTMENTS, FINANCIAL POLICIES, DUTY TO WARN, AUTHORIZATIONS, PERMISSION FOR TREATMENT OF MINORS AND ALL OTHER STATEMENTS WRITTEN IN THIS CONTRACT.

All adults who are involved in this therapy must sign below, indicating understanding of the Policies and Procedures and Agreement to enter into a Counseling Contract with Cindy Oliphant, LPC, PLLC.

Date: _____

Print Name

Signature

Print Name

Signature