

PRO-ACT
PROfessional **A**ssessment **C**ounseling and **T**raining

Client Intake Information

Client's Name (Last, First, Initial) _____ Sex: M F Age _____

Spouses Name (if married) _____ Age _____

Name of Parent or Guardian(s) if client is a minor _____

Address (Street): _____ (City) _____ (ZIP) _____

Phone Numbers/e-mail **(only include those that we have permission to call or leave a voice/email message):**

Home _____ Work _____ Cell _____ e-mail _____

Marital Status _____ Date of Marriage _____ Guardian/Spouse Name (as appropriate) _____

Client Social Security # _____ Drivers License # _____

Date of Birth _____ Occupation _____ School Attended _____

How did you find out about PRO-ACT? _____

Religious Orientation _____ Church Affiliation _____

Please make a simple statement regarding your reason for seeking counseling. _____

Family Members living at home

Name: _____ Age _____ Birth-date _____ Relationship to client _____

Insurance Information:

Insured's Name: _____ Insured Date of Birth _____

Insurance ID# _____ Soc. Sec. # _____

Mental Health Insurance Carrier: _____ Mental Health Telephone # _____

Major Medical Insurance: _____ Major Medical Telephone # _____

Group # _____ Insured's Employer _____

Medical/Health Information:

In Case of emergency you may call _____ Phone # _____ Relationship _____

Personal Physician: _____ Phone # _____

Date of last physical: _____ Major illnesses/conditions _____

Previous Counseling: Yes No If yes, when _____

With whom _____

Medications you are currently taking? _____

The undersigned authorizes the release of all client information by the therapist for the purpose of pre-certification for treatment and concurrent review, to medical review agencies and/or third party payors providing coverage. Such disclosures are limited to information that is reasonably necessary for treatment planning.

Client/Guardian Signature

Date

Consent for Release of Information for Treatment, Payment and Healthcare Operations

I hereby authorize **PRO-ACT** (office) and/or my therapist to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. **I understand that while this consent is voluntary, if I refuse to sign this consent, the office can refuse to treat me.**

I have been given a ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations.

I understand that I may revoke this consent at any time by notification in writing, but if I revoke my consent, such revocation will not affect any actions that the Office took before receiving my revocation.

I understand that the Office has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that the Office restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that the Office does not have to agree to such restrictions, but that once such restrictions are agreed to, the Office must adhere to such restrictions.

COMMUNICATIONS

I hereby authorize Office and/or my therapist to communicate with me through: **(please check where applicable)**

_____ **e-mail address** _____

Messages left on voice mail at home _____ **work** _____ **cell phone** _____

Please list any Family or Friends that PRO-ACT may release medical/billing information to:

_____ phone # _____

_____ phone # _____

_____ phone # _____

Signature of Client

Signature of Client

Date _____

Date _____

PLEASE READ THIS IF YOU ARE SEEING A LICENSED INTERN

Office appointments with our Licensed Interns are offered to our clients. Jacqualine C. Truitt, MA,LPC,LMFT,NCC is the Certified Supervisor of our Licensed Interns and as such you are legally her client and all bills will be submitted in her name . The supervisor is accessible in person or by telephone whenever needed by our Licensed Interns. You may also contact her at anytime regarding your case. There may be times when the supervisor will be present in a session either as a co-therapist or simply as an observer of the Licensed Intern.

If you have any questions, concerns, or complaints about the Notice or your medical information please contact: David or Jacqualine Truitt at 713-475-0072.

Policy and Procedures

The following information is provided to acquaint you with the policies and procedures of **PRO-ACT**. If you have any questions about this information, please feel free to discuss them with your therapist.

Lengths of Sessions:

Therapy sessions are usually 45-50 minutes. We make it a goal to start and end on time.

Scheduling Appointments:

If you wish to schedule an appointment, please call your therapist at the number on their business card Monday through Thursday between the hours of 10 a.m. and 6 p.m. and on Friday between the hours of 9 a.m. and 3 p.m. Leave a message in their mailbox and your call will be returned within the business day or in rare situations early the next morning.

Cancellation of Appointments:

If you need to cancel or reschedule an appointment, please do so at least 24 hours in advance. **Failure to do so will result in your being billed for the session.** This notice enables your therapist to give your time to someone on a waiting list or respond to an emergency case. Your consideration of this matter is greatly appreciated. **(Note: If you have insurance, your insurance company cannot be billed for a late cancellation or a no show. You will be personally responsible for payment of the entire session fee.)** Exceptions will be made in rare unavoidable situations such as illness, accidents, or death in the family.

Emergencies:

We are always available for emergency calls. To contact your therapist in case of emergency, call the answering service at **(713) 475-0072 or (281)820-8381** then dial **"0"** and you will get a live operator, tell them it is an emergency and the name of your therapist. **Your therapist or someone on call for them will be paged immediately. Our phones are answered live for emergencies 24 hours a day. Be sure to say "this is an emergency". This is very important as they have special instructions for notifying your therapist when the call is an emergency.** Please make sure that you really have an emergency if you leave this type of message (i.e. in a genuine crisis or feeling suicidal). Your therapist will stop whatever they are doing and call immediately. This means they will interrupt a session with another client, leave a meeting, etc. **If your call is not returned within 10-15 minutes, please call back and leave your message again.** **PRO-ACT** phones are answered 24 hours a day, 7 days a week. In the event that your therapist is out of town or otherwise unavailable, they will always make arrangements for another licensed therapist to handle situations that cannot wait for their return. The staff at **PRO-ACT** and the answering service will be able to contact the therapist that is on call in these instances you are ultimately responsible for your safety. If your life is in immediate jeopardy, call 911 or go to the hospital emergency room for help.

Other Telephone Calls:

If you have a routine question please feel free to call your therapist at the number provided by them or the **PRO-ACT** office. Your call will be returned as soon as possible, but remember your therapist may be in session and will have to call you when he/she has a break. If possible, leave a phone number where you can be reached. The reason for this is that if your therapist pages you, he/she may be in session when you return the page and you will just play "telephone tag." If your therapist has not returned your call and you need to leave another number where you can be reached, feel free to call again. If your question requires a lengthy conversation (over 10 minutes) or appears to be of a nature that needs to be handled in a therapy session, we will

need to schedule an extra appointment for you. Please do not use phone calls as a substitute for your appointments with your therapist. Such calls are subject to a minimum professional fee of \$25.00 - \$50.00 depending on length and are typically *not* covered by insurance. **In the event that this happens, you will be informed of the charge at time of the call.**

Caller ID Issues:

There are many times that your therapist may need to return your call from home as office hours vary from one day to the next. If your home number is blocked to anonymous callers, you will need to disconnect that service by dialing *87 on your phone. Some of our therapists keep their home number blocked for all outgoing calls and they will be unable to reach you otherwise. You can reconnect your anonymous call blocking after your call by dialing *77. If you are uncertain that your Caller ID has anonymous blocking, you may want to dial *87 to be sure. **In any event – please do not return calls to numbers that show up on your caller ID—please call the number that we leave as a call-back number.**

Therapist-Client Relationship:

It is very important that you have a good level of comfort and trust in your relationship with your therapist. Your sense of well-being and your therapist level of efficacy in treating you depends on this. We recognize in some cases that this may not always happen. Some clients and some therapists just “don’t fit”. If you should significantly disagree with or feel uncomfortable with your therapist’s clinical decisions please let your therapist know and feel free to discontinue your therapist-client relationship. We say this wholeheartedly because it is our hope for clients that they feel assured in their relationship with their therapist, be it with someone at **PRO-ACT** or somewhere else. In turn, we will also reserve the ability to end a therapist-client relationship with a client in situation where there has been client non-compliance with treatment or payment of services to the point that it is dangerous or non-therapeutic. In the extremely rare event that this should be the case, your therapist will inform you of this and provide emergency services to you for 30 days, which is a reasonable period of time that it would take for you to arrange for continuing care elsewhere.

Confidentiality:

Concerning confidentiality, “*what is said in the room, stays in the room*” with a few exceptions. If you tell me something that indicates to me that you or someone else is in danger, your therapist will, because of legal precedent and law, break confidentiality to help ensure safety. In the case of child clients, the therapist may share some general comments about the child’s therapy sessions that they think will be helpful for the parent to know, but for therapeutic reasons, the contents of therapy sessions will be kept confidential. For payment for service that is provided to you, some HMO and PPO insurance plans require that your therapist fill out forms about the course of your treatment and provide them with a copy of your medical record on their request. Certain legal situations may also force your therapist to breach confidentiality. Finally, your therapist may talk about your care with other health care practitioners who are providing treatment for you, such as your psychiatrist, your primary care physician, or the therapist on call when you therapist is out of town. If at all possible, your therapist will warn you before he/she breaks confidentiality. He/she will strive, within the confines of the law, to maintain confidentiality in your therapist-client relationship. If you would like more information regarding your privacy please read our [Notice of Privacy Practices Statement](#) posted in the waiting room and on our website: <http://www.pro-act.com>. You may also request a paper copy of this statement.

Couples and Families:

Couples and families seeking marriage counseling and/or family therapy please understand that the record of treatment services provided can not be released without authorization from all adults present in treatment.

We look forward to working with you.

Consumer Rights and Responsibilities

Consumer Rights

- Be informed of the qualifications of your counselor: education, experience, and professional counseling certifications and state licenses.
- Receive an explanation of services offered, your time commitments, and fee scales and billing policies prior to receipt of services.
- Be informed of limitations of the counselor's practice to special areas of expertise (e.g., career development, ethnic groups, etc.) or age group (e.g. adolescents, older adults, etc.).
- Have all that you say treated confidentially and be informed of any state laws placing limitations on confidentiality in the counseling relationship.
- Ask questions about the counseling techniques and strategies and be informed of your progress.
- Participate in setting goals and evaluating progress toward meeting them.
- Be informed of how to contact the counselor in an emergency situation
- Request referral for a second opinion at any time.
- Request copies of records and reports to be used by other counseling professionals.
- Receive a copy of the code of ethics to which your counselor adheres.
- Contact the appropriate professional organization if you have doubts or complaints relative to the counselor's conduct.
- Terminate the counseling relationship at any time.

Consumer Responsibilities

- Set and keep appointments with your counselor. Let him/her know as soon as possible if you cannot keep an appointment.
- Pay your fees in accordance with the schedule you pre-established with the counselor.
- Help plan your goals.
- Follow through with agreed upon goals.
- Keep your counselor informed of your progress toward meeting your goals.
- Terminate your counseling relationship before entering into arrangements with another counselor.

If you have questions about any of these consumer rights and responsibilities please discuss them with your counselor.

Thank you for allowing us the privilege to serve you.

Jacqueline C. Truitt, MA, LPC, LMFT, NCC

Owner/Director

PRO-ACT

PRO-ACT

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me) the following documents:

- **Client Intake Information**
- **Policy and Procedures**
- **Client Rights and Responsibilities.**
- **Consent for Release of Information for Treatment, Payment, and Healthcare Operations**

I have had all my questions answered fully. I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand my therapy will involve a combination of therapeutic approaches that may include insight oriented, cognitive-behavioral, Ericksonian, and/or various types of brief or solution focused psychotherapies. Interactive play therapy is often the model of choice with children. Couple therapy is based on a combination of marital therapies including communication skills training and a model called Imago Therapy. My therapist will discuss the specifics of my particular treatment plan with me and inform me of the cost of my treatment.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I know that in most cases my insurance company cannot be billed for no-shows but that PRO-ACT will charge for that appointment, The exceptions to this are clearly identifiable, for example; an accident, sudden illness, a death in the family, etc.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may refer me to another therapist or discontinue my treatment. I understand that if my insurance company does not reimburse my therapist that I am responsible for the charges for my treatment.

My signature below shows that I understand and agree with all of these statements.

Signature of client (or person acting for client)

Date

Signature of client (or person acting for client)

Date

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist

Date

_____ **Copy accepted by client**

_____ **Copy kept by therapist**