Shana R. Mercer, M.Ed., LPC S Professional Counseling – Beaumont, TX
(409) 223-1433 ____ shana.livingsuccess@hush.com www.shanamercercounseling.com

Client Intake Form

Date ______________________ Referred by ____

Name: ____

(Last) (First) (Middle Initial)

Birth Date: ____ /____ /_____ SSN: ______ - _____ - _______ Age: _______ Gender: ☐ Male ☐ Female

Local Address: ____

(Street and Number) (City) (State) (Zip)

Home Phone: __________________________ May we leave a message? ☐ Yes ☐ No

Cell/Other Phone: __________________________ May we text/leave a message? ☐ Yes ☐ No

If no, preferred method of contact: ____

In case of an emergency please notify ______________________________ Phone # ________________

Email Address: ____

Emails are encrypted in order to maintain confidentiality. A password is required to open the emails. Please answer the following security questions:

What was your hometown? ____

MARITIAL STATUS:

☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name ______________________________ Age _________ Occupation __________________

MARITAL HISTORY: (if any)

Present Marriage length ____________

Overall marriage is… ☐ Extremely Happy ☐ Frequently Happy ☐ Happy/Average ☐ Unhappy

If any children (Names & ages) ____

OCCUPATIONAL INFORMATION:

Are you currently employed? ☐ Yes ☐ No

If yes, who is your current employer/position? ____

Please list any work-related stressors, if any: ____

Health and Social Information

Are you currently

- ☐ Receiving psychiatric services, professional counseling or psychotherapy elsewhere
- ☐ Taking prescribed psychiatric medication? please list: ___________________________________
- ☐ Previously prescribed psychiatric medication? please list: _________________________________

Please check any of the symptoms that you are having:

- ☐ Depression
- ☐ Extreme Sadness
- ☐ Trouble Concentrating
- ☐ Memory Problems
- ☐ Change in Eating Habits
- ☐ Feeling Extreme Happiness
- ☐ Trouble Performing in Job
- ☐ Lack of Enjoyment of Usual Activities
- ☐ Self-Esteem Problem
- ☐ Perfectionism
- ☐ Obsessions or Compulsions
- ☐ Feeling Fearful
- ☐ Physical Complaints of Pain
- ☐ Problems with Anger
- ☐ Substance Use
- ☐ Self-harm
- ☐ School Problems
- ☐ Change in Sexual Interest/No Sexual Interest
- ☐ Thoughts About Hurting Yourself or Others
- ☐ Feeling Hopeless
- ☐ Feeling Tearful
- ☐ Change in Sleeping Habits
- ☐ Lack of Energy
- ☐ Weight Changes
- ☐ Problems Getting Along with Family or Friends
- ☐ Feeling Stressed
- ☐ Sudden Feelings of Panic
- ☐ Acting Violently
- ☐ Isolation or Withdrawal
- ☐ School Work Has Deteriorated
- ☐ Doesn’t Mind Parents, Ignores Teachers
- ☐ Sexually Promiscuous
- ☐ Falling Asleep at Work/School
- ☐ Unable to Fall Asleep or Stay Asleep
- ☐ Thoughts About Killing Yourself or Others

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family experienced difficulties with the following?

Difficulty

- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety Disorders
- ☐ Panic Attacks
- ☐ Schizophrenia
- ☐ Substance Abuse
- ☐ Eating Disorder
- ☐ Learning Disabilities
- ☐ Trauma History
- ☐ Suicide Attempts

In your own words, why have you come to see a counselor? ____

____

____

____

____

Client Agreement / Informed Consent

Overview of Services: Counseling is a collaborative process between you and a counselor to work on areas of your life and assist you with life goals. For counseling to be most effective, it is important that you take an active role in the process. Counseling activities are governed by the Texas State Board of Examiners for Professional Counselors. Psychotherapy services are offered to individual adults, couples, families, and children, usually on a once-per-week basis.

Counseling and psychotherapy both refer to a supportive and guiding relationship with a professional practitioner who has undergone extensive training and personal exploration to understand the dynamics of human experience and psychological development. There are many different definitions and philosophies of psychotherapy, and each therapist will offer their own unique approach to treatment in unison with your goals, desires and preferences.

Qualifications: I earned a Master of Education in Counseling and Development from Lamar University in Beaumont, Texas. I hold a license as a Licensed Professional Counselor Supervisor with the Texas State Board of Examiners of Professional Counselors.

Benefits: A number of benefits are available from participating in psychotherapy. Often it is helpful just to know that someone understands. Therapy can provide a fresh perspective on a difficult problem or point you in the direction of a new solution. The benefits you obtain from therapy depend on how well you use the process and put into practice what you learn. Some of the benefits from therapy include: attaining a better understanding of yourself and your personal goals, developing skills for improving your relationships, overcoming specific problem areas such as depression and compulsive behaviors, and finding resolution to the concerns which led you to seek therapy. However, there are no guarantees about what therapy will do for you. Some people find that participating in psychotherapy results in changes that were not anticipated or intended at the outset.

Risks: There are certain risks associated with the counseling process that should be understood before work progresses. For example, in counseling, there is a risk that clients will, for a time, experience uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other difficult feelings. Clients may recall unpleasant memories. Relationships are often affected as a result of therapy. Significant relationships may experience varying degrees of tension. This is often most prevalent within family relationships, but may extend beyond into one's social and professional life. Sometimes, a client's problems may temporarily worsen after the beginning of treatment. Most of these risks are to be expected when people are making significant changes in their lives. Finally, even with our best efforts, there is a risk that therapy may not yield the results that you initially desired from it.

Confidentiality: Psychotherapy, counseling, assessment, and associated services that are related to diagnosis, evaluation, and treatment services provided by licensed professionals are confidential and protected under Texas state law. The law protects the privacy of all communications between a client and a licensed professional. In most situations, information regarding your treatment can only be released to others with your written permission. However, there are legal limits to confidentiality and times when a licensed professional is obligated to disclose pertinent information, as necessary, to the appropriate authorities/agencies/individuals:

☐ If your therapist suspects that you pose a harm to yourself or others.

☐ If you report that a child, elderly person, has been or is being neglected, or physically or sexually abused.

☐ Ordered disclosure by state or federal courts.

☐ In the case of minors, parents or legal guardians have access to their child's records, unless emancipated.

☐ Family or group counseling is not legally private and can be subpoenaed.

☐ Provisionally-licensed therapists are required to discuss their cases with their supervisor.

☐ Insurance Companies and managed care companies may require a diagnosis and/or clinical information in order to pay claims or authorize sessions.

☐ Some cases are anonymously discussed with peer professionals to provide enhanced quality of service.
If I file suit against the therapist for breach of duty.

Therapeutic Relationship: The client-therapist relationship is a purely professional one in which appropriate boundaries must be maintained, despite the fact that close emotional bonds may develop over the course of treatment. Although this is sometimes difficult to understand, it is a necessary requirement for maintenance of the therapeutic environment. As

such, your therapist cannot be expected to be involved in a social relationship or friendship of any kind that exists outside of the therapy room. **Recording devices of any kind are not permitted during sessions.**

Time Parameters: Appointments are scheduled for 50-minute segments. Being late for an appointment will count against this allotted duration and the session will conclude at its normal stopping time. In certain cases, most often with couples or family counseling, sessions may be scheduled for 80-minute or 110-minute segments, as determined by you and your therapist during the initial consultation.

Fees: Counseling services are performed by fully licensed professionals. Cash and credit fees as follows:
$150/50-minute intake Session $125/50-minute individual, couples or marriage session. Insurance deductible amounts to be met will be charged at full rates until the amount is satisfied. Co-pay amounts that follow met deductibles are set by the insurance provider.

Court Fees: In unusual circumstances, you may become involved in litigation wherein you request or require a therapist's participation. You will be expected to pay for such professional time even if the therapist is compelled to testify by another party. *The minimum retainer of $1,000 is required to cover time spent in court or preparing for court. Written confirmation and payment is required from attorney and client before the date counselor receives subpoena.* Payment schedules for other professional services will be agreed to when these services are requested.

Insurance: Most major insurances are accepted for counseling services. The administrative staff will process any and all claims regarding therapy sessions. We gladly provide this service at no extra charge to the client. This will include the initial session and any subsequent sessions. You will be informed prior to your first session of any co-pay or deductible amounts so you can better prepare for any fee exchange.

Keep in mind that most insurance companies limit sessions and require a medical diagnosis in order to reimburse expenses. Such a diagnosis will often end up in your permanent insurance record. We can discuss any questions or concerns that you have about insurance reimbursement if that's something you'd like to pursue.

Payment: Payment is due at time of service delivery. If payment cannot be made for the current appointment, arrangements must be made for payment prior to the following appointment. If payment for the current appointment is not made within one week of the appointment the following appointment, sessions will be suspended until payment is made. A service charge of $35 will be charged for each check returned.________________ (Please initial here)

Cancellation: Sessions must be cancelled with at least 24-hour advance notice to your therapist to avoid penalty. Clients with recurring appointments who cancel two (2) consecutive appointments will be removed from the recurring schedule. Clients will be financially responsible for a fee of $150 for any intake session cancelled with less than 24 hours' notice or missed (no-show) and $125 for any follow-up session cancelled or missed with less than 24 hour' notice (no show) _____________________ (Please initial here)

Termination: Counseling is voluntary. Both you and your therapist reserve the right to transfer/terminate services at any time, for any reason. Should you decide to terminate treatment, please email your therapist with your decision.

Continuation of Care: In the event that termination occurs prior to the completion of client-stated goals, the therapist agrees to make reasonable efforts to ensure the client's continuation of care by making appropriate referrals to no fewer than three (3) alternative counseling sources, taking into adequate consideration the client's psychological needs and ability to pay. Such referral will be made in writing and sent to the client's address on record.

Grievance/Complaint: To file a formal complaint against a licensed professional or post-graduate intern, you may also contact the appropriate licensing board listed below:

Texas State Board of Examiners of Professional Counselors: (512) 834-6658

Contact Hours: Office hours are by appointment only and scheduled Tuesday – Friday 9:00 – 6:00 pm, Saturday 10:00AM – 2:00PM A client may cancel and reschedule sessions by using the scheduling app or by calling **409-223-1433** and leaving a message. If you need to reach me between sessions, please email me at shana.livingsuccess@hush.com

Emergency/After-Hours: If you have a life-threatening crisis, please call 9-1-1. Most hospital emergency rooms can give life-saving services. Help is also available 24hrs at the Crisis Hotline (800-937-9087) or (409-835-3355). Please note that emergency services are NOT offered by this counseling office.

Financial Responsibility: By signing below, you agree to accept financial responsibility for all services received.

I have read, understood, agree, and consent to the conditions of service stated in this agreement. I have also received the notice of privacy practices on this date and have had the opportunity to ask questions about and understand these policies.

______________________________	______________________________	____________
Signature of Client	Printed Name	Date
______________________________	______________________________	____________
Signature of Client	Printed Name	Date

Shana R. Mercer, M.Ed., LPC S
350 Pine St Ste 760
Beaumont, TX 77701
409-223-1433

Credit Card Authorization: No Show Fees and Account Balances

Clients may cancel or reschedule an appointment anytime, as long as they provide 24 hours' notice. If you cancel an appointment with less than 24 hours' notice or neglect to keep your appointment, you will be charged $$150/$125 (see informed consent). The counseling office of Shana R. Mercer, M.Ed., LPC accepts MasterCard, Visa, American Express and Discover for payment of no show fees. Complete the following form to process a credit card for these fees should they occur. If credit card information is not available a no-show retainer of $125.00 will be required.

My cancellation policy is not a penalty or a punishment. At some point you might forget an appointment, or something will come up in your schedule that will result in you missing an appointment. My clients understand that scheduling an appointment with me is like purchasing a ticket to an event. If you miss the event it doesn't matter why, you can't return your ticket for a refund.

Please PRINT CLEARLY in blue or black ink.

Account balances will be charged to the credit card you place on file.

Client Information

____
Name as it appears on credit card

____
Address

Credit Card Information

Please charge to the following credit card:

☐ MasterCard ☐ Visa ☐ Discover Card Expiration date (*Month*) ____(*Year*) _____

Credit Card No: ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐

Billing zip code for this credit card ☐☐☐☐☐ Security Code ☐☐☐

Cardholders Signature: ____

Insurance information: Assignment and Release of Information

Primary Medical Insurance Company ______________________________________

Insurance Company Telephone: ____

Group # _______________________ Policy # _______________________________

Policyholder's Name (if difference from patient) ____

DOB ________________________ Relation to Patient ______________________________________

SSN _______ - ____ - __________

Place of Employment____

Secondary Medical Insurance Company ______________________________________

Insurance Company Telephone: ____

Group # _______________________ Policy # _______________________________

Policyholder's Name (if difference from patient) ____

DOB ________________________ Relation to Patient ______________________________________

SSN _______ - ____ - __________

Place of Employment____

Assignment of Benefits

I, ____________________________ hereby authorize ____

(Name of primary insurance company)

To pay and hereby ASSIGN DIRECTLY TO Shana R. Mercer M.Ed., LPC S, all benefits rendered. **I understand that insurance filling does not guarantee payment and that is my insurance company does not pay for any reason, I am financially responsible for all charges incurred.** I further acknowledge that any insurance benefits, when received by and paid to Shana R. Mercer, M.Ed., LPC S will be credited to my account. If there is a credit on my account due to an insurance error, the credit will be absorbed into counseling sessions and no cash refund will be given. However, if a credit occurs due to our error, a cash refund will be given if the client so desires. I understand that is it my responsibility to inform Shana R. Mercer, M.Ed., LPC of any changes to my insurance. The undersigned here by utilizes the Release OF INFORMATIONRELATING TO ALL CLAIMS for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes Shana R. Mercer, M.Ed., LPC S to submit claims for benefits for services rendered without obtaining my signature on each and every claim and that a photo-static copy of this authorization shall be as valid as the original.

____ ____

Patient Name/Date Signature of Patient or Guardian/Date

Referral: Please provide the name and address for your PCP or other individual who referred you so that we may inform them that you have begun treatment. (Some managed companies requite this contact.)

PCP or referral source: ____

____

Shana R. Mercer, M.Ed.,LPC S
350 Pine St, Suite 760
Beaumont, TX 77701-2421
409-223-1433

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be involved in that treatment directly and indirectly.

* Obtain payment from third party payers.

* Conduct normal healthcare operations such as quality assessments and certifications. I have received, read and understand your Notice of Privacy Practices (NPP) containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its NPP from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the NPP.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I understand you are not required to agree to my requested restriction, but even if you do not agree, then you are bound to abide by such restrictions.

I understand that a copy of the HIPPA materials are available upon my request.

Client Name (please print):____

Relationship to client:____

Signature:____

Date:____

OFFICE USE ONLY

I attempted to obtain client's signature in acknowledgment on the NPP Acknowledgment, but was unable to do so as documented below:

_____Individual refused to sign.
_____Communication barrier prohibited obtaining the acknowledgment.
_____An emergency situation prevented me from obtaining acknowledgment.
_____Other (please specify)____
____

Date:_______________________________________Initials:_____________________________