*0*![123_1 [28136]]()**CLIENT INTAKE FORM**

You are provided an opportunity to cancel your appointment when you receive the text, phone **AND** e-mail notifications **24 hours** prior to your appointment.  Please call the office at **(409) 832-7771** *or* cancel online UPON RECEIPT of notifications if you will be unable to attend to **www.beapearl.com**.  Failure to heed to this rule will result in the following:

ALL **SAME DAY CANCELLATIONS** WILL BE CHARGED A$**60.00**CANCELLATION FEE WHICH IS**CHARGED TO THE CREDIT CARD ON FILE***.* ALL**NO-SHOW/NO-CALL**APPOINTMENTS ARE ALSO CHARGED A**$60.00**FEE THAT MUST BE PAID PRIOR TO RECEIVING A NEWAPPOINTMENT, IF NO CREDIT CARD IS ON FILE*.* **TWO (2*)***CONSECUTIVE NO-SHOW/NO-CALLS WILL RESULT IN REMOVAL FROM THE CLINIC.

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Y.S. Pearl Jessie,*** M.Ed., LPC

|  |
| --- |
| PERSONAL INFORMATION |
| Full Name: Last Name First Name Middle Initial |
|  |
| Street Address Apartment / Unit # |
|  |
| City State Zip Code |
|  |
| Home Phone Cell Phone Alternate Phone |
|  |
| Email Address |
|  |
| Date of Birth (mm/dd/yyyy) Age Social Security # |
|  / / - -  |

|  |
| --- |
|  INSURANCE INFORMATION (If EAP or CASH put N/A) |
| Insurance Provider |
|  |
| Policy # / Member ID # Group #  |
|  |
| Insured Name (If NOT Self)  |
|  |
| Relationship to Insured |
| □ Spouse □ Child/Dependent □ Self □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Insured DOB (MM/DD/YYYY) Insured Social Security # |
|  / / - -  |

**TOLL FREE CRISIS HOTLINE: 1-800-937-8097**

|  |
| --- |
|  EMPLOYEE INFORMATION  |
| Employer Name |
|  |
| Employer Address: Street Address City State Employer Phone # |
|  |
| Job Title |
|  |

|  |
| --- |
|  EMERGENCY CONTACT INFORMATION |
| Name: Last First  |
|  |
| Home Phone Cell Phone Alternate Phone |
| Relationship to you? |

|  |
| --- |
| PERSON(S) SHARING RESIDENCE |
| Name Age Occupation Relationship |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
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Please answer the following questions to the best of your knowledge.

1. **Who do you consider a part of your support system (VILLAGE)?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **What prompted you to call POWCS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **What observable changes have you noticed within yourself AND your family since the problems began? When did the problems begin?**
2. **Have you previously received** Mental Health Counseling **previously?** **Yes / No**

**If so, by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever been an** Inpatient/Outpatient **at a Behavioral Facility? Yes / No**

**If so, which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Are you currently prescribed any psychotropic medications**? Yes / No**

**If so, please list? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Any Substance Abuse usage? (Marijuana applies ) Yes / No**
2. **Is this an Employee Assistance Program (**EAP**) visit? Yes / No**

**If so, which one?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Confirm/Authorization (**Required**) # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Are you having suicidal thoughts or thoughts of SELF-HARM that require immediate attention**?** Yes / No

By signing below you are voluntarily acknowledging that you have requested AND received a copy of the disclosure titled “Your Rights and Responsibilities” and that you are giving Pearls of Wisdom Counseling Service, PLLC, the right to use the information that you willingly provided in an administrative capacity. Your information will not be sold or disclosed to third parties not affiliated with Pearls of Wisdom Counseling Service, PLLC as per regulations in connection with HIPPA. By signing below, you are giving the therapist permission to bill your insurance company for services. You are also giving the therapist permission to *release information* necessary to bill insurance company. Your therapist will only release information that is necessary for billing purposes.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

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Your Rights and Responsibilities

**All clients of Pearls of Wisdom Counseling Service have the following rights:**

● The right to be treated with dignity as a human being.

● The right to be equally considered as an individual and receive treatment regardless as to your sex, age, race, religion, color, economic status, or sexual preference(s).

● The right to receive professional care and respectful care services.

● The right to your confidentiality. Written consent must be provided by the client before any information is released, with the exception of Pearls of Wisdom Counseling Service being required by law. These areas of law include, but are not limited to imminent issues of ***suicide, homicide, and/or child abuse,*** whereas the law requires this information to be released without your consent. These areas also limit your rights to confidentiality.

● The right to know the assessment of the problem, the recommended treatment plan, and any resources available to help improve the problem.

● The right to refuse any treatment by Pearls of Wisdom Counseling Service. Regardless as to how strongly the counselor suggests that you seek help, you have the right to reject the counselor’s advice. In choosing refusal of said advice or treatment you will be advised of the consequences that may adversely follow as a result of your refusal. Please note, alternate forms of treatment or help may be available.

Your rights also include the following responsibilities**:**

● For you to be honest, open and agreeable to communicate your concerns to the counselor.

● For you to feel free to ask questions in reference to clarifying matters or in the event you do not understand a discussed matter.

● For you to communicate any uncertainties or reservations about your treatment plan to the counselor.

● For you to stick to the agreed-upon treatment plan.

● For you to communicate or report any and all changes or unexpected events in reference to your problem to the counselor.

● **For you to keep your scheduled appointments.** Please contact the office of Pearls of Wisdom Counseling Service *upon receipt* of your THREE 24-hour notifications if you need to reschedule. Failure to do so results in a non-refundable $60 NO-SHOW fee not payable through your insurance. **EAP CLIENTS**: *Please be advised missed appointments affects the total number of sessions allowed per year under the EAP as they have to be reported.*

● For you to understand you are responsible for your thoughts, feelings, actions, and your growth. The counselor is simply here to help gain understanding in reference to those thoughts, feeling, actions, and growth to the best of her ability.

**Please sign below as recognition that you have read, that you understand, and accept the information provided in this document.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client’s Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Y.S. Pearl Jessie,* M.Ed., LPC**

**Print Name**

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**OFFICE POLICIES**

**You may request a copy of this**

In order to prevent misunderstandings about office policies, please read the following:

**CONFIDENTIALITY**: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, ***except where disclosure is required by law or by court order***. The law requires disclosure where there is a reasonable suspicion of *child abuse, elder abuse or neglect*; where a client *presents a danger to self, to others, or to property*; is gravely disabled; or is *significantly impaired from drug and/or alcohol use*. In these emergency situations, Y.S. Pearl Jessie, M.Ed., LPC will do whatever she can, within the limits of the law, to prevent clients from injuring ***self or others*** and to ensure that clients receive the proper care. Y.S. Pearl Jessie, M.Ed., LPC is legally bound to keep disclosed information confidential.

In judicial proceedings, if a judge orders the records released, Y.S. Pearl Jessie, M.Ed., LPC is legally bound to release the records. In addition, she may be ethically and legally required to take action to protect others from harm even if taking this action means she reveals information about you. For example, if counselor believes a **child**, **elderly person** or **disabled person** is being **abused** or **neglected**, she **IS mandated** to report this to the appropriate state agency. If counselor believes a client is threatening serious harm to another person or property, she is required to take action by notifying the potential victim, police and/or facilitating hospitalization of the client. If counselor believes a client is a serious threat to harming themselves, Counselor may have to take protective action (arranging for hospitalization, contacting family/significant others for notification and/or contacting the police.) Counselor will maintain client case files for 7 years from the last session date.

**DUAL RELATIONSHIPS:** As your counselor and therapist, Mrs. Pearl Jessie cannot participate in what is known as dual relationship with you as a client. Dual Relationship is defined in psychotherapy as any situation where multiple roles exist between a therapist and a client. Examples of dual relationships are when the client is involved in any other relationship with therapist such as hiring a client who is a lawyer for professional reasons while receiving therapy.

**TELEPHONE & EMERGENCY PROCEDURES:** If you need to reach Mrs. Jessie, LPC between appointments, you may leave a message 24 hours a day, 7 days a week on her voice mail at (409) 832-7771. If your call is urgent and Ms. Jessie, LPC cannot call you back immediately, please call 911. If your call is a life-threatening emergency, PLEASE go immediately to the closest hospital or call 911. For this area, the local hospital is Baptist Behavioral at (409)212-5000.

**PAYMENTS**: **At each session, payment is expected for any fees due, including insurance co-pays, PRIOR TO session beginning**.

**LITIGATION LIMITATION:** Due to the nature of the therapeutic process, which often involves making a full disclosure of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, ***divorces*** and **custody disputes**, injuries,***lawsui****ts*, etc.), neither you nor your attorneys, nor anyone else acting on your behalf, will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.  If this occurs, you will be billed **$500** for every 1 hour of your therapist's time and **$3,000** for an entire day.  Fee must be paid in full (cash or credit card) prior to therapist appearing.   Please note, we also charge a fee of **$200.00** for records preparation.  ***Court fees are not reimbursable by your insurance company.***

**Initial \_\_\_\_\_\_\_\_\_\_\_\_:** **CANCELLATIONS**: All appointments cancelled LESS THAN 24 hours (same day cancellations) of your scheduled appointment will be assessed a fee of $60.00, **WHICH WILL BE CHARGED TO THE CREDIT CARD ON FILE.** **You will not be able to schedule another appointment until the fee is paid in full IF THERE IS NO CREDIT CARD ON FILE.** This fee **cannot** be processed through your insurance; therefore, it must be paid by you. You are given the opportunity to cancel your appointment when you receive the three notifications from the client portal through phone, text and e-mail, PLEASE use that opportunity to cancel your appointment.  Failure to do so will result in a charge of $60.00, NO EXCEPTIONS.  Again, your credit card on file will be charged a no-show fee for failure to cancel.

**PROGRESS NOTES & DOCUMENTS RELEASE:** Any or all request of documents and / or progress notes must be submitted in writing and attached with a “**Release of Records”** provided by our office. Please note: the requestor of the documents is responsible for the associated fees, which are as follows:  **$5.00 per printed page**.  If records are required to be mailed, requestor must prepay for the requested records and the postage in advance via **Certified Mail** which is $**15.00**.  Preparation of said records requires time away from clients and is not cost effective for therapist. so therefore, if any records are requested as a result of any legal matters by a legal office, a flat fee of **$200 is required and must be paid in advance.**

**TERMINATION**: If at any point the therapist assesses that she is not effective in helping you reach the therapeutic goals, it will be discussed with you. At that time, treatment will end and you will be given referrals to other treatment providers. You also have the right to terminate services at any time. If you wish to do so, please inform Mrs. Jessie directly so the necessary steps may be taken to discharge you from care and close your file. If you do not show up for a scheduled appointment and Y.S. Pearl Jessie, M.Ed., LPC does not have contact with you for 6 weeks, Y.S. Pearl Jessie, M.Ed., LPC will assume that you are terminating services, discharge you from care, and ***close your file***.

Our current fees are as follows**:**

* Initial Intake Appointment (60 minutes): $120.00
* Sliding scale (30 minutes): $70.00
* Subsequent (Follow-up) Therapy (50 minutes): $100.00
* Couples Therapy or Family Therapy (50 minutes): $120.00
* Appointments cancelled within 24 hours (same day): $60.00
* If you exceed your allotted appointment time, you will be charged the half-hour rate: $70.00 (especially evening appointments)
* SATURDAY APPOINTMENTS: $150

**Initial \_\_\_\_\_\_\_\_\_\_\_\_:** If you use your insurance, insurance agreements require us to provide a clinical diagnosis and, sometimes, additional clinical information, such as treatment plans or summaries before they will pay benefits. Please be prepared to provide our office with a copy of your insurance card.  **It is important to remember you always have the right to pay for services privately to avoid the issues described above. It is the responsibility of the individual to determine their insurance plan coverage if it is a** deductible or a co-pay plan. **You are responsible for any rejected or denied claims by your insurance** IN FULL**! This office WILL NOT bill insurance for couples or family counseling.**

**Initial \_\_\_\_\_\_\_\_\_\_\_\_:**  For your privacy, please **DO NOT VIDEO, AUDIO, OR DIGITALLY RECORD** your session. Please **TURN OFF** all devices.

**Initial \_\_\_\_\_\_\_\_\_\_\_\_:**  This office DOES NOT participate in the filing of any disability paperwork.. Counselor has the right NOT to complete said paperwork if it is deemed a client is seeking this office for the sake of ***malingering*** (not wanting to attend work or for the sole purpose of obtaining disability to avoid employment).  If after becoming a client in this office you later decide you want your records as part of a lawsuit, you will be required to pay the fees listed in the Litigation portion.  **NO EXCEPTIONS!!!**

**Initial \_\_\_\_\_\_\_\_\_\_\_\_:**  This counselor does NOT complete FMLA paperwork, *however*, letters pertaining to attendance will be provided for school or work-related matters that same day. Please notify counselor at the **beginning** of session if said letter is needed.

**Initial \_\_\_\_\_\_\_\_\_\_\_\_:**  This office will NOT complete paperwork for an Emotional Support Animal (ESA) unless counseling will result for a period of at least 6 sessions.  This office will not aid in individuals attending one session for the sole purpose of acquiring an ESA letter.

**Initial \_\_\_\_\_\_\_\_\_\_\_\_:**   Due to the high rate of **NO-SHOWS/NO-CALL** from new patients, any specially assigned appointments such as9:00 **AM** or5:00 **PM** will require payment be made to the website, [**www.beapearl.com**](http://www.beapearl.com)prior to confirmation of appointment.  If client attends their scheduled session, all monies, ***minus any co-pay amounts or deductibles***, shall be refunded to clients.  If a client is a no-show, the $60 will remain in effect as the NO-SHOW fee.  **This rule has become necessary due to individuals not following the 24 hour policy regarding cancellation.**

**I have read the Office Policies. I understand them and agree to abide by them.** Your signature below indicates that you are making an informed choice to consent to therapy and understand and accept the terms of this agreement.

**ClientSignature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_\_

 ***Y.S. Pearl Jessie,*** M.Ed., LPC