

Heritage Behavioral Health Center
Renee Lozano, LCSW, CTS, EMDR Certified Therapist
Art Lozano, LCSW, CTS

CLIENT INFORMATION AND CONSENT FORM

By making your first appointment you have already made progress. Deciding to begin or to resume therapy shows your courage and willingness to take risks in order to improve your life. Therapy can be a rewarding and life changing process for those who dare to risk. It is important that you be aware, however, that sometimes therapy causes us to feel worse before we feel better, simply because we are focusing on and heightening our consciousness about issues that are not always pleasant, until we discover the necessary insights or appropriate solutions. It is our hope that we can assist you in finding those solutions with the understanding that it is a joint effort between you and your therapist. We look forward to working with you and hope that we can assist you in reaching whatever goals you set. The credentials of the mental health professionals are Licensed Clinical Social Worker. Art and Renee Lozano are also Certified Trauma Specialists and Renee is a Certified Therapist of Eye Movement Desensitization and Reprocessing (EMDR) therapy.

EFFECTIVE PSYCHOTHERAPY is built from good working relationships, rapport and require mutual understanding. It is in both of our interests to convey to you the policies and procedures we use in our practice; it is your right to be an informed consumer; we are willing to discuss any questions or problems you may have.

RELATIONSHIP: Your therapist cares about helping you reach your therapeutic goals and/or personal growth. In order to accomplish this, a professional and therapeutic relationship will always be maintained. Mixing personal and professional relationships undermine the effectiveness of therapy. Moreover, dual relationships with clients violate your therapist's code of ethics. This professional relationship boundary extends to any office personnel who work at Heritage Behavioral Health Center.

CONFIDENTIALITY: Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse, abuse of an elderly or disabled person, abuse of patients in mental health facilities, sexual exploitation, AIDS/HIV infection and possible transmission, criminal prosecutions, child custody cases, suits in which the mental health of a party is in issue, situations where the therapist has a duty to warn or disclose, fee disputes between the therapist and the client and in a negligence suit or licensing board complaint brought by the client against the therapist. If you have any questions regarding confidentiality you should bring them to the attention of the therapist. By signing this information and consent form you are giving your consent to the undersigned therapist to share confidential information with all persons mandated by law, the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services. You are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result. Your employer will **not** know you are coming to therapy just because you utilize benefits provided by that company, unless you choose to tell them. It is also the policy of this office to not confirm or deny that you are a client here, including appointment times, etc., even to spouses or family members, without your permission.

For some clients there is a concern that by using insurance, a **diagnosis** considered by the American Psychiatric Association to be a "mental illness", will be generated. Concerns regarding future insurance coverage and/or job applications have been expressed. If this is a concern for you, you may be more comfortable maintaining more privacy by paying for said treatment out of pocket. If you'd like to discuss

this option, let the office coordinator or your therapist know. Payment plans can be determined that make therapy affordable for you.

In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn any person in a position to prevent harm to myself or another person, including the person in danger, and to contact the following persons in addition to medical and/or law enforcement personnel:

NAME

TELEPHONE NUMBER

CHILDCARE: We are unable to provide child care services during your therapy session. Please do not bring young children unless you provide adult supervision.

APPOINTMENTS are usually scheduled once a week and last approximately 50 minutes. Once progress has begun, they can be less frequent. More frequent sessions or intensive outpatient schedules are possible depending upon the circumstances. If you need to reschedule or cancel an appointment, please call the office at (817) 282-1911 and let us know about your schedule change or cancellation. Broken appointments are a loss to everyone. Messages can be left on the voicemail system 24 hours a day. **It is important that changes be made well in advance of your scheduled time, preferably 24 hours or more, whenever possible; a missed appointment or an appointment canceled without adequate time to fill your appointment hour will result in a \$75.00 charge.**

TRAUMA RESPONSE: Renee is on several contracts which ask her to respond to critical incident traumas which can, and usually do, effect worksites and communities. As you know, crises which result in the traumatization of individuals and groups usually occur without warning and are rarely convenient. Given the nature of this type of expertise, the call to respond may interfere with her regular hours of seeing clients. Whenever the need to cancel & reschedule clients due to this type of emergency arises, you will be contacted as soon as possible (ASAP). The situation will be briefly explained and you will be asked to reschedule your appointment. Renee is sensitive to not rescheduling her clients unless it is necessary and therefore every effort will be made to get affected clients in for a rescheduled appointment within the same week or very shortly thereafter. If you think the possibility of being rescheduled will be too disruptive or upsetting to you, please let the office coordinator or Renee know before or during your first appointment.

THE FEE SCHEDULE

Diagnostic & Evaluation Session (1st Visit – 45-50 min).....	\$150.00
Regular Office Visits (45- minutes)	\$115.00
Outside Office Work per hour (inpatient visits, court, etc.).....	\$125.00
Late Cancel (< 24 Hrs or No Show Fee's	\$ 75.00

(This is **not** a forensic practice, but occasionally we cannot escape the snare of subpoenas and required court testimony. All preparation time, records reproduction, travel time, mileage, time away from the practice will be your responsibility, since you are the client - REGARDLESS of who is requesting records or court appearance related to you; a minimum of two hours will be billed).

Written Reports (Insurance companies, supervisors, etc.)..Pro-rated at.....	\$75.00/hour
Records Reproduction.....	\$20.-\$75.00
Travel Time.....	\$60.00/hour
Mileage.....	.28/mile

PAYMENT OF FEES: Required fees and co-pays are payable at the beginning of each session with Visa or Mastercard Credit or Debit, Check or Cash. We will honor contractual agreements made with those managed health care/EAP companies which stipulate specific reimbursement restrictions and claim filing requirements. However, if you are using a managed care plan, you will be expected to pay your copay at the beginning of the session. Due to the increasing problem with obtaining accurate benefit information from managed care companies, it is sometimes necessary for us to collect the full contract rate for the first couple sessions until we receive the first insurance Explanation of Benefits (EOB) & payment. Once benefits are established, we will apply any overage to future copayments, or you can be reimbursed for any overpayment. If you are using your insurance benefits, Heritage Behavioral Health Center will file claims if requested. However, we do not file secondary insurance. If you are not using a Managed Care/PPO/HMO plan and want to file your own claim, you will be expected to make the full payment and a superbill will be given for you. **In order to take full advantage of your session time, it is requested that your check be prepared prior to beginning the session. This also helps to expedite the re-scheduling process.** Monthly payment arrangements are possible for those who have already established a record of paying as they go.

EMERGENCIES may occur. Please call the office and express the nature and urgency of the emergency on the office/therapist voicemail or to the office manager, if one is available, and she will contact the necessary clinician, schedule you to get in ASAP or give other appropriate options. Due to the fact that clients are scheduled one after another, it is not always possible to get a message or return a call immediately, but all effort is made to do so in emergency situations. If an after hour or weekend emergency occurs, the clinician's emergency numbers are given on the Heritage Behavioral Health Center voice mail. You should utilize their emergency numbers if you are in a serious crisis. A call back should come as promptly as the clinician's situation will allow. If the urgency of your need is such that you cannot wait for the phone call to be returned, you may need to contact the Crisis Intervention 24-Hr Hotline at (817) 927-5544 in Tarrant Co. and (214) 233-2233 for adults in Dallas Co. or (214) 233-TEEN for teenagers, call your insurance company for the next higher level of care coverage, call 911, or have someone take you to the nearest hospital emergency room for the necessary help. When your therapist is out of town, all clients currently being seen will be advised and an on-call therapist's name will be cited on the office voice mail to call.

DEATH OR INCAPACITY OF THE THERAPIST - In the unfortunate event that your therapist becomes unable to continue to see you due to disability or death, by your signature below you are giving permission to the office coordinator and another licensed therapist to briefly review your file for the purpose of notifying you and possibly transferring you to another appropriate therapist? If this is unacceptable for any reason, notify the office coordinator or therapist before signing this document.

Also, in the unfortunate event of your death, what becomes of your file may become an issue. It is possible that several people will want us to release information from it or even turn it over to them. It is in your best interest, as well as that of your family, and the professionals within this office, for you to tell us in advance to whom you **would** permit us to release information, **without** having a court order. You can choose to not give permission to anyone but if you want to permit one or more people, please list them on the following lines by full name and relationship, i.e. spouse, grown son/daughter, sibling, etc.

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

This signed copy will be kept in your file; if you want a copy for yourself, please ask and we will be happy to make you one. If you have questions regarding any of the above, please bring them up in session.

We look forward to working with you. If you find our services helpful, we hope that you will share our names with a friend who might also benefit from them.

I have read and understand the procedures specified above by Heritage Behavioral Health Center.

Signature - Client

Date

Signature - Spouse/Partner

Date

Witness

Date

Therapist

Date

HERITAGE BEHAVIORAL HEALTH CENTER
2485 E. Southlake Blvd., Suite 180
Southlake, Texas 76092

We request that you provide us with the following information which will be used for professional purposes only and will remain confidential.

Client Name: _____ Birth Date: _____ Age: _____
Your Name: _____ Relationship to Client: _____
Address: _____ City: _____ Zip: _____
Is it okay to mail correspondence to this address? Yes _____ No _____
If no, is there another address for mailing? _____

Email Address: _____ OK to contact via email? YES NO
Client's SS# _____ Client's Employer _____

Client's Occupation _____
Home Ph:() _____ Work Ph: () _____ Cell() _____

May we leave a brief message at home? _____ At work? _____ Cell? _____
(No detailed messages will be left at work, we will just leave a name & number if you're not immediately available)

Spouse's/Partner's Name: _____ Daytime Phone: _____

Insured's Name: _____ His/Her SS# _____

Insured's Date of Birth: _____ Daytime Phone: _____

Insured's Employer _____ Occupation _____

Insurance Co. _____ Phone # _____ Policy # _____

Group # _____ Is there a Secondary Policy? _____

If so, Name of Insured, Co. Name & SS# of Insured: _____

Reason for coming in: _____

Referred by: _____ Previous Treatment(Y/N) _____

Previous Therapists' _____ Dates: _____ to _____

_____ Dates: _____ to _____



PLEASE READ THE FOLLOWING CAREFULLY:

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Heritage Behavioral Health Center will honor contractual agreements made with those managed health care companies and Employee Assistance Programs which stipulate specific reimbursement restrictions.

I realize that I will be charged \$75.00 for appointments not canceled within 24 hours of the appointment time.

Signature _____ Date _____

How to benefit from therapy.....

Therapy is the Greek word for change. The success of our work together depends upon the quality of the efforts on both our parts, and the realization that you are responsible for life style choices/changes that may result from therapy. I hereby consent to treatment by the specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have the right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____ Date _____

I hereby authorize the release of necessary medical information for insurance or EAP reimbursement purposes.

X _____ Date _____

I authorize the payment of medical benefits to the provider of services.

X _____ Date _____

ADULT INFORMATION FORM

Name _____ Date of first Appt. _____
Date of Birth _____ Age _____ Sex _____ Married? _____
Years Married or with Partner _____

FAMILY MEDICAL & SOCIAL HISTORY:

Medications currently taking:

- 1) _____ Dosage/Freq. _____ Start Date _____ Purpose _____
- 2) _____ Dosage/Freq. _____ Start Date _____ Purpose _____
- 3) _____ Dosage/Freq. _____ Start Date _____ Purpose _____
- 4) _____ Dosage/Freq. _____ Start Date _____ Purpose _____

Prescribed by (put med # next to Dr. if med's are Rx by diff. M.D's) _____

Name of Primary Care Physician: _____

His/Her Address & Ph. Number: _____

Name of Psychiatrist _____

His/Her Address & Ph. Number: _____

Many managed care companies require that we interact with the client's psychiatrist or PCP to coordinate care. Do you give us that consent to discuss your care with the above named doctors?
Yes _____ or No _____ Please sign here for either answer _____

Date of last Medical Evaluation: _____ Date of next appointment _____

Have you ever been admitted to an Inpatient or Intensive Outpatient psychiatric program?
YES NO Medical hospital admission(s)? YES NO Please list all below:

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use recreational drugs: YES NO If no, have you used previously? YES NO
If yes, when did you stop? _____

If yes, please list:

Type of Drug	How Much	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol: YES NO If no, have you drank previously: YES NO
If yes, when did you stop? _____

If yes, please list:

<u>Type of Alcohol</u>	<u>How Much</u>	<u>How Often</u>
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments and other health problems you experience: _____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: _____

Do you have any close relative (father, mother, brother, sister) who have experienced depression or other emotional problems? Please list: _____

SCHOOL & FAMILY HISTORY:

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? YES NO If yes, please explain: _____

What was the last year of school you completed? _____ If you did not complete high school, please explain why _____

What school are you attending or last attend or graduate from?
School _____ Year(s) _____
Currently attending above school? Yes _____ No _____

How would you describe your current emotional support network? _____

Please check the information which applies to your parents:
Are they biological or adoptive parents? _____

MOTHER	_____ living	FATHER	_____ living
	_____ deceased		_____ deceased
	_____ married		_____ married
	_____ divorced		_____ divorced
	_____ remarried _____ #of times		_____ remarried _____ (#of times)

Do you consider someone else (stepparent, grandparent, etc) to be one or both of your "real" parents? If so, who _____

Where do your parents live: Mother _____
Father _____

Describe your relationship with your mother while growing up: _____
currently: _____

Describe your relationship with your father while growing up: _____
currently: _____

List first names and ages of brothers & sisters, including yourself:

<u>Name</u>	<u>Age</u>	<u>Relationship</u> (Natural, step, half, etc)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any family problems that occurred while growing up relating to: alcohol/drug abuse, sexual/physical/emotional abuse: _____

MARITAL HISTORY: Current marital status: _____ Single/never married
 _____ Married _____ Separated, When? _____ / _____ Divorced, When? _____
 _____ Widowed, When? _____ / _____ Living with someone. If currently married,
 when were you married? _____ If living with someone, how long have you lived
 together? _____ How many times have you been married? _____.

Please list your children:

<u>Name</u>	<u>Age</u>	<u>Relationship(natural/step)</u>	<u>Lives with</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Others living in the home with you:

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>AGE</u>	<u>GRADE/OCCUPATION</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MENTAL STATUS: Please check any of the following that describe how you have been feeling or acting in the last two to six months or related to the reason you are here:

sad/depressed anxious panic angry irritable resentful
 worthless tearful jealous hopeless helpless loss of sexual interest
 guilty ashamed loss of interest in activities normally interesting or fun low
 energy extreme mood fluctuations (discrete periods of euphoria & high energy followed by
 periods of deep depression & isolation) aggressive thoughts of death loss of
 concentration phobia(s) of: _____
 obsessive thinking re: _____
 compulsions: _____
 intrusive thoughts or images frightened hypervigilance

Describe any other feelings you have had or elaborate on any checked from above: _____

Have you had any change in sleeping habits? YES NO Describe _____

Have you had any change in your appetite? YES NO Describe _____

Has there been weight loss ___ or gain ___? How much? _____ In what time span? _____

Have you ever considered suicide in connection to your **current** problems? YES NO

If so, please give a brief description with dates: _____

Have you ever **considered** suicide in the **past**? YES NO

Have you **attempted** suicide recently or in the past YES NO If so, please give a brief
 description with dates: _____

Have you had any homicidal thoughts recently or concerning your current problem?

YES NO If yes, please explain _____

LEVEL OF FUNCTIONING: List or describe any current impediments or problems in daily behavioral, psychological, social or occupational functioning, i.e. isolation from friends/family, significant difficulty getting to work or making self do daily tasks, poor concentration or impaired memory, severe financial strain, recent divorce or problems with supervisor, etc.

THOUGHTS: Please check any of the following that apply to you.

- I sometimes hear voices even though no one nearby is talking to me
- I sometimes feel that forces outside of me control me
- I sometimes feel that other people control my thoughts
- I sometimes have the same thought over and over and cannot control it.
- I sometimes feel that someone is out to hurt me or do something against me.
- I am sometimes unable to control my behavior; Please explain_____

Is there any other information regarding you or your family that you would like to share with your therapist that is not covered on this form, or use this space to complete earlier responses.

Thank you!