Heritage Behavioral Health Consultants

1325 Campbell Rd, Houston, TX 77055 713-365-9015 heritage@heritagebehavioral.com

Julie Summers, M.A., LPC-S
Julie Ottosen, M.A., LPC
Jennifer Hofman, M.A., LPC
Angela Jones, Ph.D., LPC
Sarah Jane Paton M.A., LPC
Jill Early, M.Ed., LPC
Allie Sauls, M.A., LPC
Ana Ince, M.Ed., LPC
Shannon Owen, M.A. LPC-Associate
Under Supervision of Julie Summers, M.A., LPC-Supervisor
Emily Rucker, Behavior Specialist, Life Coach

Jasmine Boone, Ed.D., LPC
Charles Reed M.A., LPC
Elizabeth Warren, M.A., LPC
Taylor Garcia, M.A., LPC
William Kao, M.A., LPC
Jennifer Welch, M.A. LPC
Paige Cryer, M.A., LPC
Hannah Barnes, Health Coach, Birkman Consultant
Farrin Velasco, M.A. LPC-Associate
Under Supervision of Julie Summers, M.A., LPC-Supervisor

Welcome to the practice of Heritage Behavioral Health Consultants. We are pleased you have chosen our office and will assure you that we are working with you in a caring and professional manner. Please take a few moments to read our office policies and do not hesitate to ask any questions you may have. These policies are further detailed in the Notice of Privacy Practices following this form.

WHAT IS COUNSELING? The therapy relationship is a partnership between a therapist and a client that is for the client's benefit alone. While the immediate aim of counseling is to relieve discomfort and distress, most therapies have a longer-range goal: *to modify or change patterns of thinking, feeling, and acting that are producing stress, while learning new, more effective and satisfying ways of living. Each patient is unique with unique therapeutic needs.* At Heritage, we meet you where you are, learn from where you have been and empower you to get where you need to go.

OFFICE HOURS

Regular support staff hours are from 8:00am to 5:00pm Monday through Friday. Each clinician sets his or her own schedule and will work with you to schedule a mutually agreeable time.

SESSIONS

Full sessions are 45 minutes and half sessions are 25 minutes long. In order to ensure that your time is respected and waiting time does not interrupt your schedule or ours, every effort is made to start and stop on time. Extended sessions can be arranged when necessary, that will include an additional fee. Moreover, Heritage employees train LPC Associates, and as a part of their training, you may be asked to allow them to sit-in your sessions from time to time.

CANCELLATIONS

There is no charge for missed appointments IF APPOINTMENT IS CANCELLED AT LEAST 24 HOURS IN ADVANCE. If the appointment is for Monday, the cancellation may be made-by leaving a message with the answering service. WE DO CHARGE FOR APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE.

PRIVACY PROCEDURES

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), Heritage Behavioral Health Consultants is required to: 1) maintain the privacy of your health information, 2) provide you with a Notice to our legal duties and privacy practices with respect to the information that we collect and maintain on you, 3)

abide by the terms of the Notice, 4) notify you if we are unable to agree to a requested restriction, 5) accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. Please refer to our Notice of Privacy Practices for detailed information.

EMERGENCY SERVICES

In the event of an emergency including, but not limited to suicidal ideations, homicidal ideations, severe decompensation, acute psychotic symptoms, and/or other urgent issues requiring immediate action please call 911, the Crisis Hotline (713-HOTLINE), or go to the nearest emergency room. Your therapist will usually be available to assist you personally should an emergency consultation becomes necessary: however, at times, a colleague may cover calls or you may have to contact emergency services (911) if no colleagues are immediately available. You may reach us at (713) 365-9015, leave a message and a call back number on your therapist's private voicemail. Again, if this is an emergency please call 911 and do not leave a voicemail. If the phone consultation requires more than 15 minutes, you will be billed for time.

If your therapist reasonably believe that you are a danger, physically, behaviorally, emotionally, or mentally, to yourself or another person, you specifically consent for me to warn the person in danger, and to contact the following persons, in addition to emergency medical services, your primary care physician, other medical personnel, law enforcement, officers of the court, and/or 911 staff:

List three people to contact during an emergency (Person name, relation, and phone number)

1. ____
2. ____
3. ____

TECHNOLOGY

As a policy, we typically do not accept social media request from clients or follow clients on social media. Please see attached Social Media policy for further details. We may choose to utilize text, phone, and email as a form of communication for schedule or facts. Your therapist will NOT provide counseling via email or text. They will respond and let you know that they have received your message. Your therapist can receive voicemails and emails from their business phone and computer that are directed to their cell phone. Please know that your therapist will respond to your voicemails and emails during office hours. However, do not leave emergency information on this voicemail or email and call 911.

FEES

Payment is due at the time of service rendered in the form of cash, check or credit card. We do not file insurance in this office; however, for those clients that belong to an insurance company that wish to file, we will give you an itemized statement so that you can file it with your insurance company in order to have them reimburse you directly.

It is the policy of this practice to turn delinquent accounts over to collection after 90 days. If it becomes necessary to do this, there will be an additional 10% charge to the outstanding balance.

SERVICE TERMINATION
You acknowledge that the services provided by me to you are voluntary. You or your therapist may elect to terminate services after appropriate and therapeutic termination occurs for any reason.

CUSTODY & CONTROL OF RECORDS In the event of licensees' death, incapacity, or termination of the licensees' counseling practice, patient records will be maintained by Heritage Behavioral Health Consultants Inc. and housed at 1325 Campbell Road for the required seven-year term. After the seven-year term has passed, patient records will then be destroyed.

PERSONAL RELATIONSHIPS
Our goal is that we will develop a positive, rewarding relationship. At this time, please take a few minutes to fill out the enclosed information so that we may better help you achieve your goals.

TYPES OF THERAPY AND ASSESMENTS
A variety of therapies are available depending on your needs and wishes. During your first visit, you and one of our clinicians will evaluate together what issues you wish to address and the type of therapy that would be most appropriate for you.

Please check each type of therapy or assessment you feel may be appropriate.

___ Marriage or Relationships Counseling
___ Individual Counseling
___ Parent Consultation
___ Family Therapy
___ Attention Deficit Disorder Assessment
___ Psychological Testing

CONSENT TO SERVICES
By signing this Informed Consent document, you acknowledge, understand, and agree that you have both read and understood all the consents, terms, and information contained in this Informed Consent and the attached Notice of Privacy Practices. Additionally, you acknowledge, understand, and agree that many opportunities have been offered to you to ask questions and seek clarification of anything in this Informed Consent that was unclear to you. You acknowledge, understand, and agree that you have been given a copy of all pages of this Informed Consent and Notice of Privacy Practices.

I HAVE READ AND FULLY UNDERSTAND THE **PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT** AND AGREE TO ITS TERMS.

Patient's Full Name (please print): ____

Signature: ____ Date: ______________

I HAVE RECEIVED A **NOTICE OF PRIVACY PRACTICES** AND AGREE TO ITS TERMS.

Patient Signature: ____ Date: ______________

Clinician Signature: ____ Date: ______________

Adult Patient Information

Date: ____________________ Clinician Name: ____

Patient's Name: ____ D.O.B.: _________________

Sex: M_____ F______ Patient's Address: ____

City:_____________________________ State:______________________ Zip Code: _____________________

Home Phone:______________________________________ Cell Phone: __________________________________

Email: ____ Occupation: ________________________________

Employer: ____ Work Phone: __________________________________

Business Address: ____

Emergency contact:____Phone: ______________________________

Referred by: ____

Would you like an invoice after every visit? ☐ Yes ☐ No

Is it alright to leave a voicemail on your answering device? ☐ Yes ☐ No

At which phone number? ☐ Home ☐ Cell ☐ Work

Would you like to keep your credit card info on file for ease of payment: ☐ Yes ☐ No

Card Holder Name: ____

Credit Card No.: ____

Exp. Date: ________________________

CVV Code: _______________ (3-digit code on back of card)

Credit Card Billing Address: ____

Signature: ____

Please complete if patient is female:

Menstrual History:

Age at onset: ______ Date of last period: ______ Cycle: _____ days Duration: _____ days

Regular: Yes No Pains/Cramps: Yes No PMS: Yes No

Pregnancies:

Total # of pregnancies: ______Miscarriages: ______ Terminations: _____ Age of youngest living child:

Diet and Exercise:

Weight: Current____________ 1 year ago ______________ Desired ____________

Are you on a special diet? ____

Indicate which of the following symptoms you have experienced

- ☐ Fatigue/ lack of energy
- ☐ Weakness
- ☐ Lack of Sleep
- ☐ Sleeping too much
- ☐ Increase/Decrease of appetite
- ☐ Increase/Decrease in weight
- ☐ Repetitive/senseless thoughts
- ☐ Repetitive/senseless behavior
- ☐ Sad/down in the dumps
- ☐ Depressed
- ☐ Irritability/anger
- ☐ Nervousness
- ☐ Fearful feelings
- ☐ Frequent crying
- ☐ Frequent negative thinking
- ☐ Frequent thoughts of death
- ☐ Suicidal thoughts
- ☐ Homicidal thoughts
- ☐ Fainting/ feeling faint
- ☐ Tremors
- ☐ Trembling/shakiness
- ☐ Seizure/convulsions
- ☐ Skin rash
- ☐ Aggressive/violent behavior
- ☐ Seeing things that are not real
- ☐ Hearing things that are not real
- ☐ Difficulty making decisions
- ☐ Difficulty concentrating
- ☐ Memory problems
- ☐ Worthless feelings
- ☐ Excessive guilt feelings
- ☐ Helplessness
- ☐ Hopeless feelings
- ☐ Sweating
- ☐ Dizziness/light headedness
- ☐ Unsteady feelings
- ☐ Jumpiness
- ☐ Keyed up/ on edge
- ☐ Restlessness
- ☐ Constant worry
- ☐ Panic
- ☐ Feeling life not worth living
- ☐ Increase/decrease in sex drive
- ☐ Fear of going crazy
- ☐ Fear of dying
- ☐ Feeling of unreality
- ☐ Feeling in dream-like state
- ☐ Isolation/withdrawal
- ☐ Double vision
- ☐ Difficulty in focusing vision
- ☐ Eye pain

- ☐ Eye discomfort in bright light
- ☐ Sinus pain or congestion
- ☐ Increase/decrease in tearing
- ☐ Increase in sensitivity to sounds
- ☐ Ear infections
- ☐ Joint pains or stiffness
- ☐ Backache
- ☐ Muscle tension
- ☐ Muscle pain/soreness
- ☐ Swelling of hands/feet/ankles
- ☐ Leg cramps
- ☐ Numbness/tingling in limbs
- ☐ Foot problems
- ☐ Trouble walking
- ☐ Balance problems
- ☐ Cold/clammy hands
- ☐ Unable to sit still
- ☐ Chest pain/discomfort
- ☐ Palpitations
- ☐ Difficulty swallowing
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Vomiting
- ☐ Food intolerance
- ☐ Fear of losing bowel control
- ☐ Inability to control bowels
- ☐ Shortness of breath
- ☐ Dry mouth
- ☐ Unusual taste sensation
- ☐ Inability to control urine
- ☐ Penile/vaginal sores
- ☐ Penile/vaginal discharge
- ☐ Difficulty in sexual frustration
- ☐ Breast discharge
- ☐ Other: _______________

Chief Concern: Please describe the main reason that you here today: ____
____
____
____

Educational History:

High School(s): ____
College(s): ____

Treatment History:

Have you ever received psychological, psychiatric or counseling services before? ☐ Yes ☐ No

When	From whom	For what problem	With what results

Have you ever taken medications for psychiatric or emotional problems? ☐ Yes ☐ No

When	From whom	For what problem	With what results

Personal History:

What is your marital status? ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower ☐ Single ☐ Dating

Do you have children, and if so, how many? ☐ Yes: ______ ☐ No
How many times have you been married? __________ Number of Years Married? __________

Please describe the following relationships in your family of origin:

Your parents' relationship with each other: ____
____
____

Your relationship with each parent and with other adults present: ______________________
____
____

Your relationship to your brothers and sisters, in the past and present: ________________
____
____

Family History:
In either side of biological parents, is there any history of the following:

- ☐ Alcoholism________________________
- ☐ Allergies _________________________
- ☐ Anxiety __________________________
- ☐ ADHD ___________________________
- ☐ Asthma __________________________
- ☐ Bowel Disease ___________________
- ☐ Cancer __________________________
- ☐ Compulsions_____________________
- ☐ Depression _______________________
- ☐ Diabetes ________________________
- ☐ Drug Abuse _____________________
- ☐ Emphysema ____________________
- ☐ Epilepsy _________________________
- ☐ Heart Disease ___________________
- ☐ HIV _____________________________
- ☐ Hormone Disorders________________
- ☐ High Blood Pressure _______________
- ☐ Kidney Disease ___________________
- ☐ Liver Disease _____________________
- ☐ Physical Abuse ___________________
- ☐ Phobias _________________________
- ☐ Psychiatric Hospitalization _________
- ☐ Rage ____________________________
- ☐ Schizophrenia ____________________
- ☐ Sexual Abuse _____________________
- ☐ Thyroid Disease __________________
- ☐ Tremors or tics ___________________
- ☐ Ulcers ___________________________
- ☐ Learning Disabilities ______________
- ☐ Suicide/ Attempts ________________
- ☐ Other ____________________________

Present Relationships:
How do you get along with your present spouse or partner if you have one? _______________
____
____

Please list your spouse/partner's physical health problems, chemical use, and mental or emotional difficulties if any: ____
____

How do you get along with your children if you have any? ____
____
____

Please list your children's physical health problems, chemical use, and mental or emotional difficulties if any: ___
____
____

Your most important friends, past and present:

Name	Good Parts of Relationship	Bad Parts of Relationship

Personal Abuse History:

☐ I was not abused in any way ☐ I was abused ☐ I am not sure if I was abused

If you know you were abused, please list all incidents below using the following letters:
P = physical, such as being shoved, hit, or beaten.
S = Sexual, such as touching/molesting, fondling, or intercourse
N = Neglect, such as failure to feed, shelter, or protect you
E = emotional, such as humiliation, verbal attacks

Your age	Kind of abuse	Effects on you	Did you tell anyone?	Consequences of telling

Substance Use:

Have you ever felt the need to cut down on your drinking?	☐ Yes	☐ No
Have you ever felt annoyed by criticism of your drinking?	☐ Yes	☐ No
Have you ever felt guilty about your criticism of your drinking?	☐ Yes	☐ No
Have you ever taken a morning "eye-opener"?	☐ Yes	☐ No

How many drinks (beer, wine, or hard liquor) do you consume each week, on average? ____________________

How much tobacco do you smoke or chew each week? ____

Which drugs (not including prescription medications) have you used in the last 10 years? __________________
____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often do you use them, their effects, and so forth: ____
____

Legal History:

Are you presently suing anyone or thinking of suing anyone? ☐ Yes ☐ No

Is your reason for coming to see us related to an accident or injury? ☐ Yes ☐ No

Is your appointment required by a court/police/probation/office/parole? ☐ Yes ☐ No

If you answered yes to any of the above questions, please explain: ______________________________________

____

____

Your current attorney's name: ______________________________ Phone: ____________________

Please list all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones using the following letters:

Jurisdiction: (**F** =Federal, **S** = State, **Co** = County, **Ci** = City)

Sentence: Time served and type of sentence (**AR** = accelerated or alternate resolution, **CS** = community service, **F** = fine, **I** = incarceration, **Pr** = probation, **Po** = parole, **O** = other, **R** = restitution)

Date	Charge	Jurisdiction	Sentence	Probation/Parole Officer

Are there any other legal involvements that we should know about? ______________________________

____

Current medications:

Name	Dosage	Reason for taking

Other:

Is there anything else you feel is important for your therapist to know that we have not asked about on these forms?

____

____

____

Patient Signature: ____ **Date:** ____________

Social Media Policy

This outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet.

“Friending and Fanning”

I may or may not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Instagram, etc.) This can blur the boundaries of our therapeutic relationship.

I keep a Facebook Page for my professional practice to allow people to share my blog posts and practice updates with other Facebook users. You are welcome to view my Facebook Page and read or share articles posted there, but becoming a fan is not recommended. I believe having clients as Facebook Fans creates a greater likelihood of compromised client confidentiality and I feel it is best to be explicit to all who may view my list of Fans to know that they will not find client names on that list. In addition, the American Counseling Association’s Ethics Code prohibits my soliciting testimonials from clients, former clients, or any other persons who may be vulnerable to undue influence.

“Following”

We publish a blog on the company’s website, personal sites, and post psychology/counseling news on Facebook and Instagram. I have no expectation that you as a client will want to follow my blog or any social media stream. My primary concern is your privacy. If you share this concern, there are more private ways to follow my professional page on a social media platform (such as using an RSS feed). Note that I may or may not follow you back knowingly. I may or may not follow current or former clients on blogs or any social media platforms.

Interacting

Please do not use messaging on social networking sites such as Twitter, Facebook, Instagram, and/or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

If you need to contact me between sessions, the best way to do so is by phone. Direct email (provided separately) is second best for quick, administrative issues such as changing appointment times. See the email section below for more information regarding email interactions.

Email

We prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you could become a part of your legal record.

Use of Search Engines

It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there *might* be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

Business Review Sites

You may find my private practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client. The American Counseling Association's Ethics Code states under C.3 Advertising and Soliciting Clients that "Counselors who use testimonials do not solicit them from current clients, former clients, or any other persons who may be vulnerable to undue influence. Counselors discuss with clients the implications of and obtain permission for the use of any testimonial."

Of course, you have a right to express yourself on any site you wish, but due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative.

If you feel I have done something harmful or unethical and you do not feel comfortable discussing it with me, you can always contact the Texas State Board of Examiners of Professional Counselors, which oversees licensing, and they will review the services I have provided.

Texas State Board of Examiners of Professional Counselors| Complaints and Management and Investigative Section | P.O Box 141369, Austin, Texas 78714-1369

Conclusion

Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

Please sign below indicating that you understand all information in the "Social Media Policy"

______________________________ ______________

Client Signature Date