



CompassionWorks

Jordan Shafer, MS, LPC

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(214) 668 2727 - Direct Line; (972) 342 2448 - Appointments

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Welcome to my practice:

I am pleased that you are coming to talk with me so that you can get more of what you want out of life. Typically, I do a combination of Cognitive-Behavioral counseling and Eye-Movement Desensitization Processing (EMDR), the degree of which depends upon how our conversations unfold.

Attached to this letter are several forms that you may wish to complete and bring with you to the first session. Please do not be concerned if you do not finish them, can't answer all of the questions or don't even do them. That's fine. We'll go over them when you get here and they can be completed at that time.

As part of our time together, I'd like you to be aware of the following:

- I am a Master's level Licensed Professional Counselor in the state of Texas, and am a Certified EMDR therapist and an Approved EMDR Consultant in training.
- I work with adolescents and adults on a variety of issues and with older children on specific-issue trauma.
- If you are already working with a therapist and coming for an EMDR consultation and referral, that's fine. With your permission, I will work in conjunction with your current therapist, if that's what you desire.
- You are in control of this relationship and you may choose to end it at any time.
- If we meet in a public or social situation your confidentiality will be protected and we will acknowledge knowing each other only if you wish to do so.
- If you ever have a complaint, you are invited to address it with me directly. However, if it cannot be resolved you would then contact the Texas State Board of Examiners of Licensed Professional Counselors (800) 942-5540 to file a formal complaint.
- You are responsible for all fees that your insurance denies, rejects, or fails to pay. Rates and fees are outlined in the attached forms.
- You will be coming to a home office, which is very private in a residential neighborhood.

Please sign below to confirm that you have read and agreed to the above information:

Client/Parent of Client

Date

Statement of Confidentiality

Confidentiality is defined as keeping private the information shared by you, the client, with this office. As a client you have the right to withhold or release information to other individuals or agencies; however, a statement signed by you is required before any information may be released by this office. This right applies with the following exceptions:

1. When a court of law subpoenas information shared by you with your counselor;
2. Mental Health Professionals shall report if required by any of the following laws:
 - The Family Code, Chapter 34, concerning abuse or neglect of minors;
 - The Human Resources Code, Chapter 48, concerning abuse, neglect or exploitation of elderly or disabled persons;
 - The Health and Safety Code, Chapter 161, concerning sexual exploitation by a mental health provider;
 - Health and Safety Code, Chapter 611.004, concerning the probability of imminent physical injury by the client to the client or others or there is a probability of immediate mental or emotional injury to the client.

When it is at all possible, you will be informed of the need to share information.

Consent for Treatment

I voluntarily agree to receive evaluation/mental health treatment, evaluation/chemical dependency treatment, and/or evaluation/training-coaching-educational services for developmental disorders by Jordan Shafer, MS, LPC. I understand that I may discontinue treatment and/or discontinue treatment and/or withdraw my consent for treatment at any time.

I agree to the above limits of confidentiality and understand their meanings and ramifications. I also agree to enter into counseling services with Jordan Shafer.

Signature of Client

Date

CLIENT INFORMATION

Today's Date _____ Cell Phone _____ No Message

Client Name _____ Home Phone _____ No Message

Address _____ Business Phone _____ No Message

City, State, Zip _____ Email _____

Sex M F Age _____ Birthdate _____ Single Married Separated Divorced

Occupation: _____ SSN: _____

Employer: _____ Education (highest grade completed or degree)

Employer Address _____

Person financially responsible & relationship to client (if different) _____

Phone number _____ Birthdate _____

Household Members (Include Name, Relationship, and age):

INSURANCE COVERAGE

Insured Name _____ ID Number # _____ Birthdate _____

Insurance Company _____ Phone _____

Insurance Address _____

Group # _____ Subscriber # _____ Authorization # _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____

Phone Numbers _____

MEDICAL INFORMATION

Have you previously received any type of Mental Health Services? Y N, If yes, When? _____

Where? _____ With Whom? _____

Current Medication and Dosage

PCP or Prescribing Physician _____ Phone _____

Office Location _____

RATES

Services are billed at the following rates:

50 minute sessions are \$140.00

Group sessions are \$50.00

Late Cancellation/No Shows are \$75.00

Court testimony is \$200.00/hr with a prepaid retainer fee of \$1500.00

Insurance rates and co-pays are as contracted with the insurance provider

LEGAL CONSULTING UNDERSTANDING

This office does not do custody evaluations or make recommendations regarding custody agreements or legal marital issues. Counseling, consultation, and psychotherapy is often provided to children and adults who are making changes in their lives or dealing with difficulty in a life situation.

In order to protect the confidentiality of all parties involved, neither testimony nor summary of sessions for the purpose of custody or divorce issues will be provided. The content of any session will not be discussed with any legal representative.

If, however, a subpoena to testify or provide session information is ordered by a presiding judge, the fee to the party demanding such services will be \$200 per hour for all activity related to providing such a service including travel, etc. A retaining fee of \$1500.00 must be prepaid.

24 HOUR - CANCELLATION POLICY

The session charge is \$140.00 per hour. (Clients with insurance are charged according to contracted rates set by their insurance provider.)

I understand that changes or cancellations made with less than 24 hours notice are subject to the late cancellation fee of \$75.00. If you wish to cancel or change a scheduled appointment, please call the Appointment Desk, giving 24-hours notice. The number to call is (972) 342-2448.

Please be aware that your appointment time is a time-slot reserved and set aside for you, and a late cancellation makes it unlikely that your time can be filled

Late Cancellations, for any reason, and Missed/No-show appointments, for any reason, incur a \$75.00 charge, and are the full responsibility of the client.

This is true for appointments such as EAP, and those covered by insurance; appointments, such that, if attended would not have a personal out-of-pocket cost, or for which there would be a co-pay only.

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my or my family's medical status.

I certify that I or my family member(s) is covered by insurance with:

and assign directly to *Jordan Shafer, MS, LPC*, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Jordan Shafer to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Insured/Guardian

Date

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL/COUNSELING INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information, and how we may use and disclose your health information.

We may use and disclose your psychological/counseling records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Therefore, information may be shared by other healthcare providers who are treating you for the same condition.

Payment means such activities as obtaining reimbursement for services, confirmation coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other mental health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request; except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information:

- The right of restrictions on certain uses and disclosures of protected health information which includes any and all persons with the following exceptions:
 - Legal parents or guardians of minor patients

- Ordered disclosure from a court of law
- In cases of child or elder abuse
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information in the event the original information is inaccurate.
- The right to receive an accounting of disclosures of unprotected health information.
- The right to obtain a paper copy of this Notice from us upon request.

We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This Notice is effective _____20_____, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice or Privacy Practice, and to make the new Notice provisions effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised Notice of Privacy Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this Notice, or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

I AGREE TO THE ABOVE STATED CONDITIONS OF "HIPAA" AS THEY APPLY TO ME AND COMPASSIONWORKS. A COPY OF THESE PROVISIONS HAS BEEN MADE AVAILABLE TO ME.

Signature and Date

Printed Name

Presenting Issues Questionnaire

Name: _____

Date: _____

Only check “yes” if the issue described cause you significant distress and/or cause problems at home, work or in relationships.

Yes	No	Do you frequently have difficulty getting to sleep or staying asleep?
Yes	No	Does lack of sleep make you feel unrested or cause you to function poorly during the day?

Yes	No	Do you have anxiety or worry excessively (more than the average person) about things such as work, finances, loved ones?
Yes	No	Do you find it difficult to control worry and anxiety?

Yes	No	Do you have unexpected or “out of the blue” periods of intense fear associated with symptoms such as shakiness, shortness of breath, and/or racing heart?
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Yes	No	Do you experience intense feelings of anxiety or fear that you will be humiliated or embarrassed in front of others?
Yes	No	Do you avoid or anxiously endure things such as speaking in public, parties, dating, writing or eating in front of others?

Yes	No	Are you bothered by intrusive thoughts or mental images?
Yes	No	Do you have to perform repetitive behaviors (e.g. hand washing or checking), or mental rituals (e.g. counting, repeating words) to control your anxiety or distress?

Yes	No	Have you experienced a traumatic event(s) that threatened or actually caused serious physical injury to yourself or others?
Yes	No	As a result, do you have significant stress such as flashbacks, nightmares, persistent anxiety, or feelings of emotional numbness?

Yes	No	Do you have times when you feel depressed or down most of the day, nearly every hour?
Yes	No	Have you lost interest, motivation, or pleasure in usual activities?

Yes	No	Do you have chronic difficulties paying attention?
Yes	No	Do you find it hard to be still?

JORDAN V. SHAFER, M.S., L.P.C.

Yes	No	Do you sometimes act before you think?
Yes	No	Do you have distinct periods of time when you are different than your normal self – you either feel high/full of energy, or are persistently angry?
Yes	No	Does this behavior cause you, or others, problems? (Don't include alcohol or drug related states.)
Yes	No	Have you, or others, been concerned about your alcohol consumption?
Yes	No	Have you tried to cut down or felt guilty about drinking alcohol?
Yes	No	Do you have eating binges at times when you eat a very large amount of food within a two-hour period?
Yes	No	Do you use tobacco (cigarettes, snuff, chewing tobacco)?
Yes	No	Do you take drugs to get high, feel better, or change your mood?
Yes	No	Do you use illegal drugs?
Yes	No	Do you have a lack or lost of interest in sex or decreased arousal?
Yes	No	Have other people expressed concern that you are too thin?
Yes	No	When you were a child, and perhaps as an adult, did you have difficulty making friends, or did you not want to make friends?
Yes	No	Did you have, and perhaps still do, difficulty understanding other people's feelings
Yes	No	Did you have, and perhaps you still do, a special interest(s) that took up much of your time?

PERSONAL HISTORY

Are you: Single Married Separated Divorced Widowed

Number of marriages _____ Duration of each _____ Number of children _____ Gender and age of each _____

Number of times you and your partner separated during your current marriage _____

Do you have significant medical problems? Yes No

If yes, describe _____

Are you currently taking any medications? Yes No If yes, please list medications.

If yes, describe _____

How much alcohol or other recreational drugs, if any, do you consume per week?

Amount _____ Frequency _____

Last use _____ Duration _____

Past therapy experience Individual Marital Family Group

Other _____ Result _____

FAMILY HISTORY

Was your childhood home broken by the death of one or both of your parents? Yes No

Was your childhood home broken by divorce? Yes No

Were you raised by foster, adoptive, or stepparents? Yes No

Are your parents or parent-substitutes still living? _____

If living, their present age? Father _____ Mother _____

If deceased, date of death? Father _____ Mother _____

Please list brothers and sisters in birth order, including yourself:

Name	Age	Living?	Education	Occupation	Marital Status

Has a member of your family experienced any of the following

- Sexual abuse Physical abuse Verbal abuse Emotional abuse Serious physical illness
 Mental illness Alcohol/Drug abuse Eating disorder Suicide attempt Suicide

Have you experienced any of the following:

- Sexual abuse Physical abuse Verbal abuse Emotional abuse Serious physical illness
 Mental illness Alcohol/Drug abuse Eating disorder Suicide attempt Suicide

PERSONAL INFORMATION

To what degree do you feel stressed by:

	Not at all			Moderately				Completely		
	1	2	3	4	5	6	7	8	9	10
Your current job (Including your jobs at home)	1	2	3	4	5	6	7	8	9	10
Your immediate family	1	2	3	4	5	6	7	8	9	10
Your extended family	1	2	3	4	5	6	7	8	9	10
Other sources of stress in your life (Please specify) _____	1	2	3	4	5	6	7	8	9	10

To what degree do you feel you are involved with:

	Not at all			Moderately				Completely		
	1	2	3	4	5	6	7	8	9	10
Church or religious groups?	1	2	3	4	5	6	7	8	9	10
Friends/neighbors	1	2	3	4	5	6	7	8	9	10
Your local community	1	2	3	4	5	6	7	8	9	10
Other groups Please specify) _____	1	2	3	4	5	6	7	8	9	10

OTHER INFORMATION WANT ME TO KNOW

Difficulty you are seeking help with: _____
