Compassion Works

Jordan Shafer, MS, LPC
(972) 342 2448
(972) 638 8522 (fax)

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

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CLIENT INFORMATION

Today's Date _____ Best Phone _____ ☐ No Message

Client Name _____ 2nd Phone _____ ☐ No Message

Address _____

City, State, Zip _____ Email _____

Sex ☐ M ☐ F Age _____ **Birthdate** _____ ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Child

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 _____

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RATES

Services are billed at the following rates:

50 minute sessions are $140.00

80 minute sessions are $185.00

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

Insurance is out-of-network - As a result, payment is requested at the time of service for which you will be provided a receipt that you can file with your insurance company or apply to your Flexible Spending Account.

You can call your insurance company and ask about "out-of-network" outpatient mental health and substance abuse coverage and they will give you a description of the benefit. I am a Licensed Professional Counselor with the state of Texas.

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.

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24 HOUR - CANCELLATION POLICY

I understand that changes or cancellations made with less than 24 hours notice are subject to the full session fee.

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

_____ ***initial*** **Late Cancellations, *for any reason*, and Missed/No-show appointments, *for any reason*, incur the full session charge, and are the full responsibility of the client.**

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.

_____ _____

Signature of Insured/Guardian Date

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HIPPA Notice of Privacy Practice

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

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- 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

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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?

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?
Yes	No	Do you sometimes act before you think?

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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?

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LIFE TRAUMA INVENTORY

1. Have you ever been in a serious disaster (for example, an earthquake, hurricane, large fire, explosion) __Yes __No

2. Have you ever seen a serious accident (for example, a bad car wreck or an on-the-job accident) __Yes __No

3.Have you ever had a very serious accident or accident-related injury (for example, a bad car wreck or an on-the-job accident) __Yes __No

4.Was a close family member ever sent to jail __Yes __No

5.Have you ever been sent to jail __Yes __No

6.Were you ever put in foster care or put up for adoption __Yes __No

7.Did your parents ever separate or divorce while you were living with them __Yes __No

8.Have you ever been separated or divorced __Yes __No

9.Have you ever had serious money problems (for example, not enough money for food or place to live) __Yes __No

10. Have you ever had a very serious physical or mental illness (for example, cancer, heart attack, serious operation, felt like killing yourself, hospitalized because of nerve problems) __Yes __No

11. Have you ever been emotionally abused or neglected (for example, being frequently shamed, embarrassed, ignored, or repeatedly told that you were "no good") __Yes __No

12. Have you ever been physically neglected (for example, not fed, not properly clothed, or left to take care of yourself when you were too young or ill) __Yes __No

13. WOMEN ONLY: Have you ever had an abortion or miscarriage (lost your baby) __Yes __No

14. Have you ever been separated from your child against your will (for example, the loss of custody or visitation or kidnapping __Yes __No

15. Has a baby or child of yours ever had a severe physical or mental handicap (for example, mentally retarded, birth defects, can't hear, see, walk) __Yes __No

16. Have you ever been responsible for taking care of someone close to you (not your child) who had a severe physical or mental handicap (for example, cancer, stroke, AIDS, nerve problems, can't hear, see, walk) __Yes __No

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17. Has someone close to you died suddenly or unexpectedly (for example, sudden heart attack, murder or suicide) __Yes __No

18. Has someone close to you died (do NOT include those who died suddenly or unexpectedly) __Yes __No

19. When you were young (before age 16). did you ever see violence between family members (for example, hitting, kicking, slapping, punching) __Yes __No

20. Have you ever seen a robbery, mugging, or attack taking place __Yes __No

21. Have you ever been robbed, mugged, or physically attacked (not sexually) by someone you did not know __Yes __No

22. *Before age 16*, were you ever abused or physically attacked (not sexually) by someone you knew (for example, a parent, boyfriend, or husband, hit, slapped, choked, burned, or beat you up __Yes __No

24. Have you ever been bothered or harassed by sexual remarks, jokes, or demands for sexual favors by someone at work or school (for example, a coworker, a boss, a customer, another student, a teacher) __Yes __No

23. *After age 16*, were you ever abused or physically attacked (not sexually) by someone you knew (for example, a parent, boyfriend, or husband hit, slapped, choked, burned, or beat you up) __Yes __No

25. *Before age 16*, were you ever touched or made to touch someone else in a sexual way because he/she forced you in some way or threatened to harm you if you didn't __Yes __No

26. *After age 16*, were you ever touched or made to touch someone else in a sexual way because he/she forced you in some way or threatened to harm you if you didn't __Yes __No

27. *Before age 16*, did you ever have sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened to hurt you if you didn't __Yes __No

28. After age 16, did you ever have sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened to harm you if you didn't __Yes __No

29. Are there any events we did not include that you would like to mention __Yes __No

30. Have any of the events mentioned above ever happened to someone close to you so that even though you didn't see it yourself, you were seriously upset by it __Yes __No

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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

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PERSONAL INFORMATION

To what degree do you feel stressed by:

	Not at all				Moderately				Completely	
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	1	2	3	4	5	6	7	8	9	10

in your life (Please specify) _____

To what degree do you feel you are involved with:

	Not at all				Moderately				Completely	
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	1	2	3	4	5	6	7	8	9	10

Please specify) _____

OTHER INFORMATION WANT ME TO KNOW

_____

_____

_____

_____

Difficulty you are seeking help with:_____

_____

_____

_____

_____

_____

_____