LM Counseling Services, PLLC
5616 FM 1960 Rd. E. Ste. 290C
Humble, TX 77346
281-323-1494
Fax: 281-446-5727

WELCOME!

Thank you for choosing LM Counseling Services as your behavioral healthcare provider. Our services are designed to provide each individual with the appropriate level of care to reach their highest potential in a caring and professional environment to encourage change and transformation for a strong and healthy life.

Please provide complete and accurate information on the attached forms to ensure that you receive the best possible care.

If there are any questions or concerns, please address these issues with the therapist at your first session.

LM Counseling Services

Client Intake Form

Today's Date: _____

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____ Gender: M or F

Street Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Is it okay to leave a message? Yes ___ No ___

Cell Phone: _____ Is it okay to leave a message? Yes ___ No ___

Work Phone: _____ Is it okay to leave a message? Yes ___ No ___

Email Address: _____

Employer/School: _____ Occupation:_____

If Client is a minor:

Mother's Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Father's Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Have you ever seen a mental health provider? Yes___ No___

If yes, who: _____ When: _____

Reason for currently seeking therapy:

_____

_____

_____

LM Counseling Services

INSURANCE AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payers, billing agents and/or other health practitioners as is required for authorization or billing purposes.

I authorize and request my insurance company to pay directly to the therapist insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

As a courtesy we will bill your insurance company, HMO, responsible party or third-party payer for you if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling/therapy services, we request that you pay the balance due at that time. **You must provide a credit card to be kept on file to pay for charges not covered by your insurance, missed sessions, or per request by client.**

The full fee of a therapy session in the amount of $ _____ will be charged for any missed/no show sessions; to avoid this charge please call your therapist at least 24 hours in advance to cancel an appointment.

Insurance Information

Name of Insured: _____ Date of Birth: _____

Insured's Address: _____

Phone #: _____ Relationship to Client: _____

Insurance Company: _____

Policy ID #: _____ Group #: _____

Phone # for Insurance: _____ Copay Amount: _____

Number of Visits Allowed: _____ Pre-Authorization #: _____

Credit Card Information

Card Holder's Name: _____

Credit card #: _____ Exp. Date: _____

CVV2 #: _____ (3-digit number on the back of your card)(4-digit number on the front if using American Express)

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By providing my signature, I am authorizing the use of insurance and/or credit card information to pay for any services provided by LM Counseling Services, PLLC

_____ _____

Signature of client or parent if client is minor Date

Hope M. Otto, MEd, LPC-Associate, NCC

Under supervision of Lilia Mitchell, LPC-S, DPC

THERAPY INFORMATION DISCLOSURE STATEMENT

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps create the safety to take risks and the support to become empowered to change. As a client in therapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There re also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you. My Responsibilities to You as Your Therapist

Confidentiality

Except for certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. I will always act to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you choose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you. It is important to inform you, that I may participate with other colleagues to discuss some of the psychotherapy cases, I will not disclose any identifying information, that way your privacy will be protected.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I

think I will have to put these into effect.

(1) If I have good reason to believe, that you will harm another person. I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
(2) If I have good reason to believe that you a e abusing or neglecting a child or a vulnerable adult or if you give me information about someone else who is doing this, I must inform child Protective Services within 48 hours and Adult Protective Services immediately, or
(3) if I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this; however, I will explore all other options with you before I take this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.

Qualifications

I have a Bachelor of Science in Psychology and a Master's degree in Counseling and Development. I am a Licensed Professional Counselor Associate under the supervision of Lilia Mitchell who is a License Professional Counselor Supervisor. I am also a National Certified Counselor by the National Board of Certified Counselors. I am a member of the American Counseling Association. I have experience with individuals dealing with anxiety, trauma, grief, loss, self-esteem and persons with special needs. I also have experience with adolescents and young adults dealing with transitioning issues relating to school and/or life changes.

Therapy Process and Relationships

I believe that therapy is a collaborative and interactive process between a client and a therapist. Effective therapy requires that the client and the therapist develop a relationship based on mutual trust and respect I believe that each client is an individual with unique concerns, strengths, values, etc. Please know that I am a professional that is committed to your welfare.

By the end of the first or second session, I will be able to tell you how I see your case and how I think we should proceed. I view therapy as a partnership between us. You define the problems or concerns be worked on; I use special knowledge to help you make the changes you want to make. Psychotherapy is not like visiting a medical professional. It requires you very active involvement; it requires your best efforts to change thoughts, feelings, and behaviors. For example, I want you to tell me about important experiences, what they mean to you, and what strong feelings are involved. This is one of the ways you are an active partner in therapy.

I expect us to plan our work together and figure out a treatment plan to follow. We will list the areas of concern and how they will be addressed. From time to time, we will look together at our progress and goals. If we think we need to, we can change the treatment plan, its goals, or its methods. Participation in therapy involves listening to the therapist, being honest, discussing concerns about the process and completing outside assignments when appropriate.

The Benefits and Risks of therapy

Therapy also has potential risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary., and sometimes disruptive to their relationships you already have, you may find your relationships with me to be a source of strong feelings. It is important that you consider carefully whether these risks are worth the benefits for you changing. Most people who take these risks find that therapy is helpful. However, even with the best efforts, there is a risk that therapy may not work out well for you.

While you consider these risks, you should know that there are benefits to therapy. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved or the problems solved. Client's relationships and coping skills may improve greatly.

You have the right to ask question about anything that happens in therapy. I am always willing to discuss how and why I have decided to do what I am doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and request that I refer you to someone else if you decide I am not the right therapist for you. You are free to leave therapy at any time. It is important to understand that we have a professional relationship. If I see you in a public setting, in an effort to protect your confidentiality, I will not acknowledge you. I will wait for you to speak to me before acknowledging you.

Office hour/Contact Me

I cannot promise that I will always be available. However, I do have online telehealth hours as well as in person hours on Saturdays. I usually do not take phone calls when I am with a client. You may leave a

message and a phone number to return your call to. Please only leave your name and phone number but not any confidential information or what you are calling regarding. This will protect your privacy and help obey the rules mandated regarding confidentiality. I will return your phone call within 24 hours if not sooner. Generally, I will return messages daily except on Saturdays, Sundays and holidays.

If you have a behavioral or emotional crisis or emergency, and are unable to reach me immediately by telephone, you or your family member should call 911 or the Crisis Line at 713-468-5463. For nonemergent concerns, please feel free to leave me a message and I will get back to you as soon as possible at 832-569-2151.

Cancellations/Missed Appointments:

In the event that you are unable to keep an appointment, please reach me at 832-403-8375 as soon as possible, at least 24-hour notice in advance. Appointment cancellations less than 24 hours head of time are charged full fee. All missed/no show appointments will be charged the full fee.

Grievances:

If you are unhappy with what is happening in therapy. I hope you will talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I have been unwilling to listen and respond, you may contact my supervisor Lilia Mitchell LPC-S, DPC at 281-323-1494.

Client Consent to Therapy

If you have any questions regarding any of the information on the Therapy Information disclosure Statement, please feel free to ask.

By signing these policies,

(1) I understand and agree to the stated receipt of the Policies and Practices to Protect the Privacy of your Health Information.
(2) I have read, understand and received a copy of the Therapy Information Disclosure Statement outlining the therapist's responsibilities and policies.
(3) Understand that the Licensed Professional Counselor Associate conducting business at 3718 Grand Hills lane, Friendswood, Texas 77546, or at LM Counseling office in Humble Texas is under supervision by Lilia Mitchell, LPC-Supervisor, DPC and any legal action taken against this practitioner will include the supervisor.
(4) Understand and agree to the stated practice policies as listed above and give full consent for myself or my minor child, _____to participate in psychotherapy. I certify that I, _____have the legal right to seek and authorize treatment for my minor child or myself.

Sign and date this form if you agree to the terms stated in the Therapy Information Disclosure Statement:

Clients Name_____

Clients Guardian Signature_____ Date_____

Licensed Professional Counselor-Associate Signature _____ Date _____

INFORMED CONSENT FOR ONLINE Individual or Group COUNSELING by Hope M. Otto, MEd.,
LPC-Associate, NCC under supervision by Lilia Mitchell, LPC-S, DPC

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. If the client is a minor, the parent and or guardian must give explicit permission for the LPC- Associate to conduct counseling with their child and adhere to confidentiality rules same as in person sessions.

Technology

- Hope M. Otto, LPC-Associate, NCC under the supervision of Lilia Mitchell, LPC-S, DPC will use HIPPA compliant video services through Doxy.me
- The client is responsible for securing his or her own computer hardware, internet access points, and password security.
- The LPC-Associate, Hope M. Otto and supervisor Lilia Mitchell, LPC-S, DPC is not liable for confidentiality breaches when they are caused by client error.
- The LPC-Associate, Hope M. Otto and supervisor Lilia Mitchell, LPC-s, DPC is not responsible for their client's equipment failure, e.g. camera, and/or Internet service.
- The LPC-Associate, Hope M. Otto and supervisor Lilia Mitchell, LPC-s, DPC is not responsible for lapses in confidentiality that are in direct response to the client's actions.

Disconnection Problems

- If video services are not available due to an unplanned equipment or service malfunction, sessions will occur via telephone. The counselor will call the client on the designated phone number given within the first online counseling session.

Recordings Are Prohibited

- Clients are not allowed to make an audio or video recording of any portion of the session.

Risk of Harm

- Online therapy is not a crisis based clinical service.
- Online psychotherapy may not be appropriate for clients with active suicidal or homicidal thoughts, or clients who are experiencing acute mental health problems, such as manic or psychotic symptoms.
- It is the responsibility of the client to inform their LPC-Associate if they are at risk of harm to self or others.
- At intake, a client who reports being at risk of harm to self or others, will not be offered online psychotherapy services from LPC-Associate under the supervision of Lilia Mitchell, LPC-DPC except during COVID-19 pandemic or anytime the LPC-Associate and Supervisor,agree based on client assessment..

- If a client who was not formerly at risk, should become at risk of such harm to self or others, they must immediately report it to their LPC-Associate, Hope M. Otto. In such cases, LPC-Associate will consult with supervisor regarding risk assessment.

Confidentiality Restrictions

- The laws that protect the confidentiality of any medical information also apply to online psychotherapy.

- Information about the client will only be released with his or her express written permission, with the exceptions of the following cases
    - If the LPC-Associate, Hope M. Otto determines risk of self-harm.
    - If the LPC-Associate, Hope M. Otto determines risk of harm to others.
    - If the LPC-Associate, Hope M. Otto is informed about or suspects abuse, neglect, or exploitation of a minor or of an incapacitated adult
    - If the LPC-Associate, Hope M. Otto believes that someone's mental condition leaves the person gravely disabled.

Records

- The LPC-Associate, Hope M. Otto, will maintain records of online counseling and/or consultation services.
- All clinical records will be maintained as required by applicable legal and ethical standards according to the various counseling professions licensing boards, i.e. American Counseling Association and National Association for Social Workers.

Payments

- Credit card or other online payment arrangements will be made at intake.
- A form of reliable payment must be established before the first session occurs.

No Shows or Late Cancellations

- A fee of $30 will be charged to clients who do not show or who do not cancel their appointments within 24 hours of their scheduled appointment.
- Late cancellations and no shows will incur a $30 fee, which must be paid before the client receives his or her next online psychotherapy session with their counselor.

Group Counseling Disclaimer

Although the identity of all members will be kept confidential by the Hope M. Otto, MEd., LPC-Associate, NCC and Lilia Mitchell, LPC-S, DPC, please maintain the confidentiality of each member of the support group. It is important that all members feel safe and look as our group as a safe place to share their feelings.

Client signature

I understand the risks and limitations to online psychotherapy. By signing this consent, I agree to abide by its content. I acknowledge that all counseling sessions will be conducted online through a secure online platform.

Client Signature _____
Minor's Full Name_____
(Guardian Signature if a minor) _____
Relationship to
Minor_____
Today's Date_____

LM Counseling Services, PLLC
Alexis McCray, M.A., LPC-Intern Supervised by Dr. Lilia Mitchell, LPC-S, DPC
5616 FM 1960 Road East, Suite 290C, Humble, TX 77346
Email: alexis@broadeninghorizonscounseling.com
Office: 281-323-1494 Fax: 281-446-5727

Self-Pay Agreement

Client Name: _____

Date of Birth:_____

I am signing this agreement to indicate that I am seeking treatment with LM Counseling Services, PLLC and to attest that I understand my treatment, starting on _____ (date), will not be covered by insurance because the therapist providing services is ineligible to be on insurance panels at this time.

_____ Extended session agreement: I understand that insurance typically covers only one 50-minute couples/family session per day, or one 45- or 60-minute individual session per day, depending on the plan. I understand my therapist is NOT a provider for my plan, I understand I will be expected to pay in full for the entire extended session.

I have chosen to begin/continue treatment with my provider on a self-pay basis starting _____(date), which is no earlier than the date below. I agree that the provider may collect charges for the proposed services at the rates outlined below:

Description of Services to be Provided	**Approximate Cost**
Teletherapy couples/family session 50-minute	$30
Individual Teletherapy 50 minute session	$30
Additional 10-minute add-on to session	$10

I understand plan maximums that apply to medically necessary covered services will not apply and will not limit the amount I may become obligated to pay for the proposed services. I understand that I have a right to a copy of this form. This consent is subject to revocation at any time except to the extent that action has been already taken in reliance thereon. I understand that in signing this I waive any future right to be reimbursed by my insurance plan and/ or provider for services that have already been provided.

I have read and understand this agreement. By signing this agreement, I know that I am creating a binding contract that is legally enforceable against me by the provider.

Credit Card Information

Card Holder's Name: _____

Credit card #: _____ Exp. Date: _____

CVV2 #: _____ (3-digit number on the back of your card)(4-digit number on the front if using American Express) .

By providing my signature, I am authorizing the use of credit card information to pay for any services provided by LM Counseling Services, PLLC

Signature of client or parent if client is minor _____ Date _____