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:

____

____

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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

***Please keep the Policies and Practices for your records**

Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. The information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable laws and the professional Codes of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes, PHI will be disclosed only with your authorization.

Required by Law: Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA (Health Insurance Portability & Accountability Act) without an authorization:

Abuse and Neglect
Judicial and Administrative Proceedings
Deceased Persons
Emergencies

Law Enforcement
National Security
Public Health
Public Safety (Duty to Warn)

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department)
- Required by court order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing.

- Right of Access to Inspect and Copy: You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. A reasonable charge may be required to cover the cost of copies.
- Right to Amend: If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- Right to an Accounting of Disclosures: You have the right to request an accounting of certain disclosures that we make about your PHI.
- Right to Request Restrictions: You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- Right to Request Confidential Communication: You have the right to request that we communicate with you about treatment matters in a certain way or at a certain location.
- Right to Copy of this Notice: You have a right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, please speak with your therapist. If there is no resolution with your therapist, you have the right to file a complaint in writing with the Secretary of Health and Human Services at 200 Independence Ave, SW Washington DC 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

LM Counseling Services

Notice of Privacy Practices/Basic Rights

Receipt and Acknowledge of Notice

Client Name: ____

DOB: ______________________________ SSN: _________________________

I hereby acknowledge that I have received and been given an opportunity to read a copy of basic rights and privacy practices. I will request a copy if needed. I understand that if any questions regarding the Notice or my privacy rights I can contact my therapist (Adriana Martinez – 281-813-4158 or Lilia Mitchell- 281-323-1494).

Client Signature: ____ Date: _________________

Parent, Guardian, or Personal Representative Signature: ____

Date: _______________________________

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.). We hold the right to ask for appropriate documentation.

Client Refuses to Acknowledge Receipt:

Therapist Signature: _______________________________ Date: __________________________

Lilia Mitchell, MEd, 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 to 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 are 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

With the exception of 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 chose, 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 my 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, 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 are abusing or neglecting a child or 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, 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, a master’s degree in Counseling and a Doctor of Professional Counseling. I am a Licensed Professional Counselor/Supervisor issued by the Texas State Board of Examiners for Professional Counselors and am certified counselor by the National Board of Certified Counselors. I am a member of the American Counseling Association. I have experience helping individuals dealing with issues of domestic violence, depression, anxiety, grief and loss, trauma, stress management, self-esteem, and persons with special needs.

Therapy Process and Relationship

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 your 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 then change our 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 emotional 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 the relationships you already have. You may find your relationship with me to be a source of strong feelings. It is important that you consider carefully whether these risks are worth the benefits to you of 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 also 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. Clients' relationships and coping skills may improve greatly.

You have the right to ask questions 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 can 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. Contacts, other than chanced meetings, will be limited to scheduled appointments at this office. 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 I acknowledge you.

Office Hours/Contact Me

I cannot promise that I will be available at all times. Although I am in the office Mondays and Wednesdays from 10:00 am to 8:00 pm and Tuesdays and Thursdays from 10:00 am to 3:00 pm, I usually do not take phone calls when I am with a client. You can always leave a message with the answering service or on voicemail after 5:00 pm, and I will return your call as soon as I can. Generally, I will return messages daily except on Saturdays, Sundays, and holidays.

If you have an emergency or crisis, tell this to my answering service, who will try to contact me. If you have a behavioral or emotional crisis and cannot reach me or my answering service immediately by telephone, you or your family member should call 911 or the Crisis Line at 713-468-5463. For non-emergent concerns, please feel free to leave me a message and I will get back to you as soon as possible at 281-323-1494.

Cancellations/Missed Appointments:

In the event that you are unable to keep an appointment, please reach me at 281-323-1494 as soon as possible, at least 24-hour notice. Appointments cancelled less than 24 hours ahead 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 can file a complaint with the Texas State Board of Examiners of Professional Counselors by mail at Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369 or call 1-800-942-5540.

Please Keep this Form for your Records

LM Counseling Services

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 polices,

(1) 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 psychotherapists conducting business at 5616 FM 1960 East, Suite 216 Humble TX 77346, are all sole practitioners and any legal action taken against one of the psychotherapists may not include the others.*

(4) *Understand and agree to the stated practice policies as listed above and* give full consent for my minor child, ____________________________, to participate in psychotherapy or myself. 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:

Client's Name (print): ____

Client/Guardian Signature: ___________________________________ Date: ___________

Therapist's Signature: ___________________________________ Date: _________________