JULIA C. STACY, LPC-S

LICENSED PROFESSIONAL COUNSELOR
& LPC SUPERVISOR

214.908.8985
Julia@juliastacy.com

ADULT INTAKE FORM

Name: _____ Date: _____

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

Cell Phone #: _____ Work #: _____

Permission to call you on cell? Yes No Permission to call you at work? Yes No

Date of birth: _____ Age: _____ Sex: _____

Employer: _____ Occupation: _____

Spouse's Employer: _____ Occupation: _____

Marital Status: ____ Single ____ Married ____ Divorced _____ Widowed ____ Separated _____

Length of current relationship _____ Length of current separation/divorce/widow _____

Previous significant relationships:

Name Beginning date Ending date Reason for ending

Who currently lives in your household? Please list name, age, sex, relationship.

Please give any information about your family that seems especially significant:

List any support systems that you have:

Name of Primary Care Physician: _____ Physician's Phone #: _____

Date of last physical: _____ Date of last office visit: _____

In case of emergency, my therapist can notify (please include name, address, telephone number, and relationship):

How did you hear about Julia Stacy, MA, LPC-S? _____

What is the main problem that caused you to seek help?

What are the main symptoms that you are experiencing:

When did the problem first begin:

How have you attempted to resolve the problem:

Describe any stressors in the past year including any losses/changes:

List any current or previous psychological or psychiatric care, counseling, and/or evaluations. Please include date, location, and mental health professional's name.

Provider/Therapist/Hospital Date(s) Comments

List any medication you are currently taking or have taken in the past 6 months

Drug Dosage/amount Frequency Comments

Please list any current medical problems you are being treated for or has been treated for in the past 2 years:

Condition Treating professional Date of diagnosis

Please check all that might apply to you:

___ Depression ___ Anxiety ___Stress ___ Panic Attacks ____ Fear/Phobia(s)

___Grief/recent loss ___ Low self-esteem ___ Chronic pain ___ Frequent illness

___ Substance abuse ___ Job related issues ___ Paranoia/hallucination ___ Relationship issues

___ Physical/Emotional/Sexual abuse ____Family of origin issues ___ Memory problems

___ Concentration problems ___ Legal difficulties___ Sleep problems/changes in sleep

___Muscle aches ___ fatigue ___ other

Physical concerns/complaints:

___change in appetite __back pain ___stomach distress ___allergies___ headaches___ stiff neck

___sexual dysfunction ___eating issues

Family of Origin: Mother Father Brothers Sisters Grandparents Aunts Uncles Cousins

Depression _____

Rages _____

Mood swings _____

Bipolar _____

Anxiety/Panic Disorder _____

Obsessions _____

ADHD _____

Schizophrenia _____

Autism _____

Drugs _____

Alcohol _____

Gambling _____

Abuse _____

Deceased? _____

Suicide _____

Please give any other pertinent information that you feel may be helpful at this time:

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THERAPY INFORMATION AND CONTRACT

Welcome to Ms. Stacy's practice! She values the time and commitment you have made to the healing process of therapy for and/or your family. She has prepared a description of her services and explanations of my policies in order to help you better understand what to expect. **It is Ms. Stacy's policy not to release clinical records.** Please read the following information and feel free to ask any questions.

Julia Stacy is a Licensed Professional Counselor & Supervisor and is a sole practitioner in private practice. She provides individual psychotherapy for adults and takes a cognitive behavioral approach.

Appointments: Services are provided by appointment only, by calling (214) 908-8985. This number is to be used to schedule appointments and to leave messages. **Appointments are 50 minutes in length.**

There is a 24-Hour Cancellation Policy: If you can not make your scheduled appointment, you must contact Ms. Stacy's office 24 hours prior to the scheduled time or the standard rate of $150 will be billed. If you are late for an appointment, you will have a shorter amount of time and will be billed for the entire session.

Emergencies: In the event of an emergency, if you are unable to reach me, you may call or proceed to the nearest emergency room, your primary care physician, dial 988 or call the crisis hotline (972) 233-2233. Clients calling during business hours in crisis will be given the first available appointment. Crisis appointments needed that can not be accommodated immediately are typically worked in at the end of the day, or in the morning the following day.

Phone Calls: Ms. Stacy returns calls periodically during the day. If you have questions or concerns that need to be addressed before your next scheduled appointment, you may either leave a detailed message or you may send an email. Please remember to leave a phone number and/or email address where she can give you a response.

Limitations of Confidential Communications via email, cell phone, text, etc:

You may choose to contact Ms. Stacy via various forms of communication. If you choose any of these methods, you agree to the understanding that cell phone, email, and text communication are not guaranteed confidential methods of communication.

Fees: All fees are reconsidered annually. If any fees are changed, they will go into effect on January 1. You are then responsible to pay the new fee for the services provided without further notice. Payment is due at the beginning of each session. Credit/debit cards are accepted with a 3.5% processing fee. Ms. Stacy accepts private pay clients only. Ms. Stacy is reimbursable by many other insurance plans at the "out of network" rate. If this option is utilized, you are responsible for filing your own insurance claims.

Regular appointments: $150.00 per **45–50-minute** clinical hour

Intake session: The first session will be billed at **$200.00**

Phone Calls/Fax Calls: $3.00/minute (after 5 minutes)

Insufficient Funds: If a check is returned due to insufficient funds, there will be an additional charge of **$35.00**

Confidentiality:

Sessions with Ms. Stacy are confidential, except for in the following situations:

1. If the client is a danger to him/herself
2. If the client is a danger to others
3. If Ms. Stacy receives supervisions/consultation in order to provide me with quality care
4. If Ms. Stacy is subpoenaed to testify in court
5. If there is a suspicion of abuse and neglect of a child, elder, or disabled person
6. In the event of a child custody dispute
7. If therapy is court ordered
8. If the client or parent has given written permission for the therapist to discuss the case
9. If an insurance company is involved, such as in filing a claim, insurance audits, case review or appeals, requests for additional sessions.
10. **Duty to Warn:** If Ms. Stacy perceives that I may be in danger of committing harm to myself, or to others, or to others' property

I understand that Ms. Stacy may have a duty to warn if I am a danger to myself or to others. Below is a list of people (but not limited to) that she can contact in order to help prevent harm:

Name **Relationship** **Phone**

(1)_____

(2)_____

Crisis Management:

Clients considered a threat to themselves, or others are asked to consent to a verbal and/or to a written no harm contract. Clients will be scheduled for additional appointments and/or will be given phone check in times before their regularly scheduled appointment. Clients assessed to be in imminent danger will be encouraged to seek inpatient treatment. Clients who refuse to seek emergency treatment as seemed necessary by the therapist may be sent to the nearest ER via 911/ambulance.

For the purpose of providing quality care, a case may be discussed for consultation purposes by other trained clinicians. When discussed in this manner, other clinicians are expected to abide by the confidentiality guidelines.

In the case of **relationship or family counseling**, I will keep confidential (within the limited cited above) anything you disclose to me without your family member's/partner's knowledge. However. I encourage open communication between family members, and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to the therapeutic progress.

Records: A clinical chart will be maintained, and case notes will be recorded after each session. They will be kept in a confidential manner and will be retained for 7 years after the file is closed. Minor client records will be retained for 7 years after the 18th birthday.

Risks: While benefits from counseling are expected, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted.

Relationship between client and therapist: As a therapist, I can not socialize with you. In public, I will protect your confidentiality, and will not acknowledge you unless you acknowledge me first. However, there can not be any conversation of a clinical nature between us outside of a therapy appointment. The only relationship that a therapist and a client can have is a clinical one.

Termination: Some clients may only need a few counseling sessions to achieve their goals; others may require months or even years of counseling. Termination session(s) are a vital part of the counseling process, and as such, I will strongly advise you to remember to keep this in mind for yourself and for your child.

Complaints: I assure you that my services will be rendered in a professional manner, consistent with accepted legal and ethical standards. If at any time, for any reason you are dissatisfied with my services, please let me know.

Referrals: Should you and or I believe that a referral is needed, I will provide some alternatives including programs and or people who may be available to assist you. You will be responsible for contacting and evaluating those referrals and alternatives.

Agreement for Treatment: I have read and understand all pages of this form and have been given an opportunity to discuss any concerns or questions with Ms Stacy. I agree to treatment as it has been described.

Signature of Client _____ **Date** _____

Signature of Therapist _____ **Date** _____

JULIA C. STACY, MA LPC-S

CREDIT CARD GUARANTEE
FOR PERSONAL BALANCES

[ ] UNINSURED PATIENTS

Patients who are private pay, uninsured or whose insurance does not cover the cost of mental health counseling because of high deductibles or other limitations are personally responsible for payment. Any balance not paid by the end of the week will be automatically charged to your designated card below. This procedure will enable you to spread out your payments if you wish and make them smaller while keeping your account current.

[ ] INSURANCE ASSIGNMENT

My Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, I will bill your health insurance carrier on your behalf and wait up to 90 days for payment. Please remember, however, that you are ultimately responsible for payment. On Day 60, if the bill has not been paid by your insurance company, I will charge your designated credit card below for the amount of the claim. Any payments made on these claims thereafter will be immediately refunded to you.

CREDIT CARD: [ ] AMEX [ ] VISA [ ] MC [ ] DISCOVER

CARDHOLDER'S NAME

_____

BILLING ADDRESS

_____

_____

CARD# _____ **EXP.DATE** _____

THREE DIGIT CID NUMBER _____

I agree to the above terms and authorize you to charge any payment not paid by the end of each week to the above credit card.

_____ _____

SIGNATURE **DATE**