JULIA C. STACY, LPC-S
LICENSED PROFESSIONAL COUNSELOR
LPC INTERN SUPERVISOR
CHILD, ADOLESCENT AND ADULT THERAPY
15443 KNOLL TRAIL DRIVE, SUITE 210
DALLAS, TEXAS 75248
214.908.8985
JULIA@JULIASTACY.COM

ADULT INTAKE FORM

Name: _____ **Date:** _____

Parent's Name(s)_____

Mailing address: _____

City: _____ **State:** _____ **ZIP Code:**_____

Home Phone #:_____**Work #:**_____**Cell Phone #:**_____

Permission to call you at home? Yes No **Permission to call you at work? Yes No**

Date of birth:_____ **Age:**_____ **Sex:**_____

Race:_____ **Religion:**_____ **Social Security #:**_____

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, and 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 an 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 medications you are **currently** taking or has 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	Comments

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:

JULIA C. STACY, LPC-S

LICENSED PROFESSIONAL COUNSELOR
LPC INTERN SUPERVISOR

CHILD, ADOLESCENT AND ADULT THERAPY

15443 KNOLL TRAIL DRIVE, SUITE 210
DALLAS, TEXAS 75248

214.908.8985

JULIA@JULIASTACY.COM

THERAPY INFORMATION AND CONTRACT

Welcome to my practice! I value the time and commitment you have made to the healing process of therapy for you and/or your family. I have prepared a description of my 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, adolescents and children and takes a cognitive behavioral approach.

Appointments: Services are provided by appointment only, by calling (972) 733-7242. This number is to be used to schedule appointments and to leave messages. **Appointments are 45-50 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 $ 125.00 will be billed. If you are **late** for your 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, or a 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 a fax. Please remember to leave a phone number and/or a fax number where she can give you a response.

Limitations of Confidential Communication via email, cell phone, fax, 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, fax, and text communication are not guaranteed confidential methods of communication. You may be giving up your rights of confidentiality when choosing these forms 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. Cash or check are preferred and credit/debit cards are accepted with a 2.75% processing fee. Ms. Stacy accepts private pay clients and members of Blue Cross Blue Shield only. She will file the claims for you through a third party billing company and will be releasing the necessary information obtained during treatment to them to expedite insurance claims processing. 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: $125.00 per **45-50 minute** clinical hour

Intake session: The first session will be billed at **$ 175.00**

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 supervision/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 or 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 next 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 deemed necessary by the therapist may be sent to the nearest ER via 911/ambulance.
Clients are instructed via phone message to go to the nearest emergency room after hours. 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.

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 limits 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. In the case of a child client, some acting out behavior is expected to occur while they work through their experiences. It is very important for parents or guardians to inform the therapist of these changes. Together we will work to achieve the best possible results for you.

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 need only 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 or alternatives.

Agreement for Treatment: I have read and understand pages 1, 2 and 3 of this form and have been given an opportunity to discuss any concerns or questions. I agree to treatment as it has been described.

Signature of Client_____ Date_____

Signature of Parent (if Minor)_____ 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

Julia C. Stacy, MA, LPC-S

Licensed Professional Counselor & Supervisor

16800 Dallas Parkway, Suite 150
Dallas, Texas 75248
Office 972-733-7242
Fax 972-733-7257
Email Julia@JuliaStacy.com

CHILD INTAKE FORM

Child's Name: _____ **Date:** _____

Parent's Name(s) _____

Mailing address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Home Phone #: _____ **Work #:** _____ **Cell Phone #:** _____

Permission to call you at home? Yes No **Permission to call you at work? Yes No**

Child's date of birth: _____ **Age:** _____ **Sex:** _____

Race: _____ **Religion:** _____ **Social Security #:** _____

Father's Employer: _____ **Occupation:** _____

Mother's Employer: _____ **Occupation:** _____

Parent's 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 child's household? Please list name, age, sex, and relationship.

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

List any support systems that your child has other than you:

Name of Primary Care Physician: _____ Physician's Phone #_____
Date of last physical: _____ Date of last office visit:_____
In case of an 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 your child appears to be 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 medications your child is **currently** taking or has taken in the **past 6 months**

Drug	**Dosage/amount**	**Frequency**	**Comments**

Please list any **current medical problems** your child is being treated for or has been treated for in the past 2 years.

Condition	Treating professional	Date of diagnosis	Comments

Please check all that might apply to your child:

____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:

Concerns

Please mark all items that apply to your child

___Abuse/Violence in home
___Achievement/Motivation
___Anger
___Being bullied
___Bullying
___Conduct behavior
___Cries easily, feelings easily hurt
___Divorce issues
___Distractible, inattentive, poor concentration
___Disobedient, uncooperative, noncompliant
___Drug or alcohol use
___Eating problems
___Family/Personal drug use
___Fearful
___Fighting, hitting, violent, aggressive, hostile
___Grief/loss-Family/friend
___Incarcerated family member
___Low neighborhood attachment
___Mental health issues
___New student adjustment
___Parent remarriage/New partner
___Peer relationships
___Recent move
___Self-worth/Identity issues
___Serious illness in family
___Signs of depression
___Social skills problems
___Sleeping problems
___Suicidal thoughts or plans
___Tardiness/Attendance

Strengths

___Affectionate
___Cares for others
___Common sense
___Completes homework
___Conflict resolution skills
___Cooperation
___Creative activities
___Curiosity
___Decision-making skills
___Family expectations:
__High __Medium __Low
___Flexibility
___Future goals
___Honesty
___Involved in youth programs
___Independence
___Integrity
___Organization
___Parental support
___Other adult mentors
___Patience
___Personal competence
___Perseverance
___Positive peer influence
___Reads for pleasure
___Responsibility
___School achievement
___Self-control
___Self-motivation
___Sense of humor
___Sense of self-worth
___Shows effort

Other Concerns or Strengths:

_____

_____

Current Services

___After-school programs: _____
___After-school sports: _____
___Community clubs: _____
___Gifted program: _____
___Medication/s: _____
___Special education: _____

Julia C. Stacy, MA, LPC-S

Licensed Professional Counselor & Supervisor

16800 Dallas Parkway, Suite 150
Dallas, Texas 75248
Office 972-733-7242
Fax 972-733-7257
Email Julia@JuliaStacy.com

THERAPY INFORMATION AND CONTRACT (CHILD)

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Julia Stacy is a Licensed Professional Counselor & Supervisor and is a sole practitioner in private practice. She provides individual psychotherapy for adults, adolescents and children. Ms. Stacy takes a cognitive behavioral approach and specializes in child play therapy with children ages 3 and up.

Appointments: Services are provided by appointment only, by calling (972) 733-7242. This number is to be used to schedule appointments and to leave messages. **Appointments are 45-50 minutes in length.**

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Limitations of Confidential Communication via email, cell phone, fax, text, etc:
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Regular appointments: **$125.00** per **45-50 minute** clinical hour

Intake session: The first session will be billed at **$ 175.00**

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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 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 supervision/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 or 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 next 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 deemed necessary by the therapist may be sent to the nearest ER via 911/ambulance.
Clients are instructed via phone message to go to the nearest emergency room after hours. 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.

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 limits 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.

In the case of **children**, I will keep confidential (within the limits cited above) the details of the sessions. However, I will discuss general issues or concerns that arise, as well as parenting techniques/suggestions.

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. In the case of a child client, some acting out behavior is expected to occur while they work through their experiences. It is very important for parents or guardians to inform the therapist of these changes. Together we will work to achieve the best possible results for you.

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 need only 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 or alternatives.

Agreement for Treatment: I have read and understand pages 1, 2 and 3 of this form and have been given an opportunity to discuss any concerns or questions. I agree to treatment as it has been described.

Signature of Client_____ Date_____

Signature of Parent (if Minor)_____ 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

An example of handout to parent. Do not fill out.

Julia C. Stacy, MA, LPC-S
Licensed Professional Counselor & Supervisor
16800 Dallas Parkway, Suite 150
Dallas, Texas 75248
Office 972-733-7242
julia@juliastacy.com

Parent Feedback Sheet

Child's Name_____ Date_____

What delighted me the most about my child this past week was_____

_____

_____

Some happy surprises that I encountered with my child were_____

_____

_____

Current stressors that may be affecting my child are_____

_____

_____

Since the last visit, my child's symptoms have been: (please circle)

Much Better Better The Same Worse Much Worse

Please explain:_____

_____

_____

Problems or concerns that I would like Ms. Stacy to be aware of regarding my child are

_____

_____

_____

Julia C. Stacy, MA, LPC-S
Licensed Professional Counselor & Supervisor
16800 Dallas Parkway, Suite 150
Dallas, Texas 75248
Office 972-733-7242
Fax 972-733-7257
Email Julia@JuliaStacy.com

What is Play Therapy?
A Parent Handout

When parents decide to bring their child into therapy, it can be an emotionally charged and intimidating time for them. Hopefully, this can answer some of the questions you might have regarding the process.

What is Play Therapy? It is a type of therapy in which children are given the opportunity to express their feelings, practice constructive behaviors and work out solutions to problems just as adults would do in talking with a therapist. The difference is, children use play and toys as their language. Though children have often not yet developed the verbal capacity to express their feelings and experiences using words, they can naturally express themselves through play by "playing out" what is happening in their lives.

Play therapy usually occurs the same time and day each week in a private therapy room with therapeutic toys. This room becomes very important to the child because they are allowed to explore their ideas and feelings in a safe environment with an adult therapist's full attention. The play is directed by the child and revolves around specific issues, ideas and feelings they are struggling with.

The role of the trained play therapist is to observe the nature, process and content of the child's play, understanding and putting words to it. They facilitate problem solving and acceptance of responsibility.

Play therapy has been found to be effective in addressing a variety of issues like behavior problems, divorce, family conflict, school difficulties, peer problems and attachment. The parent's will receive support, education and updates on the child's progress along the way, as needed.