Dragonfly
CENTER FOR COUNSELING

16718 House Hahl Road, Suite D
Cypress, Texas 77433
Office (832)821-5819

Intake Form

Client Name: _____ Birthdate: M_____ D _____ Y_____

Address:_____

City: _____ St:____ Zip:_____

Cell Phone: _____ Secondary Phone: _____

Email: _____

Preferred Contact Method: Cell_____ Secondary_____ Email_____

Can I leave a voicemail at the phone numbers provided? Yes _____ No _____

Occupation: _____ Veteran? _____

Supportive Person Name: _____ Phone: _____
(In case of Emergency)

Who is the primary contact person (if family session): Client_____ Supportive Person_____ (Please choose one)

I, being the above named client, give permission for _____ to make, cancel or reschedule appointments on my behalf. I understand that any appointments made in my name are subject to the cancellation/no show policy described on page 3 of this document.

Client Health Information:

List any Chronic Health condition(s):_____

Current Medications/Dosage: _____

Allergies: _____

Current Behavioral Health Diagnosis (if applicable):_____

Reasons for coming to counseling:

Referral source (How did you hear about us?): _____

Dragonfly Center for Counseling provides therapy for individuals, couples, & families. Dragonfly Center for Counseling occasionally offers adult, children & teen groups/workshops. Dragonfly Center for Counseling does not provide medication of any kind. A copy HIPAA privacy laws and the following Dragonfly Center for Counseling polices is available upon request

Please read and review the following information carefully:

What to Expect from Therapy: Dragonfly Center for Counseling therapists work from a variety of therapeutic modalities in order to assist you and your family in addressing life's problems. Goals for therapy are always established through collaboration with the client(s). Dragonfly Center for Counseling therapists assist couples and families in organizing their relationships so that resources can be brought to bear on the problems being presented. Techniques that are often employed are psycho-education, modeling and role playing more positive and effective communication skills, along with between session assignments and goals created by the client(s) and their therapist. The completion of homework and client efforts to reach their goals set between sessions is necessary to get the most from the therapeutic experience.

What We Expect From Clients: Clients must make their own decisions regarding such things as educational changes, changes in marital status such as separation, divorce, reconciliation, parenting and co-parenting, custody and visitation. Dragonfly Center for Counseling therapists are here to help you think through the possibilities and consequences of decisions, but the therapist is not going to make a specific decision for you.

Privileged Communication: Dragonfly Center for Counseling and its staff make every effort to comply with HIPAA privacy laws. Dragonfly Center for Counseling therapists are required to abide by the professional practice standards for a licensee in the State of Texas and Texas State laws such as:

- Dragonfly Center for Counseling therapists do not disclose client confidences and information to any third party, except for materials shared during supervision, without a client's written consent or waiver except when mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations.
- Dragonfly Center for Counseling therapists report to the proper authorities suspected cases of child abuse/neglect, elder abuse/neglect, or disabled adult abuse/neglect and instances of danger to self or others when reasonably necessary to protect the client or other parties from a clear and imminent threat of serious physical harm.
- Certain types of litigation (such as child custody suits) may lead to court-ordered release of information without your consent.
- If a complaint is made against the therapist license, that therapist may use case information to defend this complaint.
- When working with couples, families, and/or groups, Dragonfly Center for Counseling therapists cannot disclose any information outside of the treatment context without a written authorization from all individuals competent to sign such authorization. For example, Dragonfly Center for Counseling therapists will not release any information about either or both spouses that have been seen for marital therapy to an attorney without signed authorizations from both spouses.

After-Hours Emergencies: You may contact your therapist directly via email or phone. Please talk with you therapist directly about contacting them outside of your scheduled sessions. You may also leave a confidential voicemail for your therapist at (281) 855-1982 that will be forwarded to them. In an emergency situation when an immediate response is necessary, please call 911 or go to your nearest emergency room.

Records and Court: Records can be obtained from Dragonfly Center for Counseling, P.L.L.C. (appropriate fees apply). Client files and records will be maintained in accordance with current State and Federal laws and will consider the end date of a treatment episode as the basis for file destruction. Dragonfly Center for Counseling, P.L.L.C. or its therapists do not provide Custody Evaluations or Expert Witness court testimony. If we are asked to produce a copy of client records, there is a minimum charge of $50.00 for up to 50 pages and a cost of $1.00 per page thereafter. Copy fees are due prior to release of the record. If Dragonfly Center for Counseling, P.L.L.C. or one of its therapists is subpoenaed to testify in court, the minimum charge is $750.00, due prior to the court date, for any time up to three hours (this includes preparation time, travel, and testifying), additional time is charged at $250.00 per hour.

_____ (Please initial) I have read and understand the Dragonfly Center for Counseling, PLLC policy and procedures listed on this page.

Potential Risks and Benefits of Therapy:

- Making changes through the therapy process may produce other unforeseen changes in a person's life.
- A risk in the therapy process could be feeling worse before feeling better.
- Changes in relationship patterns that may result from therapy may produce unpredicted and/or possibly adverse responses from other people in the client's social system.
- A result of therapy may be a realization on the part of the client that there are issues that may not have surfaced prior to the onset of the therapeutic relationship.
- Couple or family conflicts may initially intensify as feelings are expressed. Individuals in couple or family therapy may find that partners or family members are not willing to change.
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Please read following statements carefully and Initial Below:

Financial Responsibility: Insurance

_____ I understand that I am ultimately responsible for knowing what my plan does and does not cover, and the administrative rules. (i.e.: in-network: out of pocket balance, copayment, coinsurance, deductible, Health-Savings Account balances)

_____ As a courtesy, DCFC will verify your eligibility and benefits. However, DCFC cannot guarantee that the information received is accurate due to insurance policy changes and real-time/up to date system information. DCFC will bill your insurance company with whom we have a contract agreement.

_____ I understand that once my benefits have been determined, payments of any copays, coinsurance, deductible and fees are required at the time of services rendered.

_____ I understand that once my insurance company has processed a claim, any balance as determined by my insurance plan to be "patients responsibility" and/or "non-covered service" will be my responsibility.

_____ I understand that if I disagree with the "patient responsibility" amounts due to our office per my insurance's explanation of benefits, I will call my insurance company and our office for further explanation.

_____ I understand that failure to provide current insurance information to our office and/or reply back to insurance's request for additional information may result in the entire bill being my responsibility.

_____ I understand that any outstanding balance owed to the office is also due, unless payment arrangements have been made in advance with the office.

_____ I give Dragonfly Center for Counseling, PLLC permission to submit claims to my insurance.

Financial Responsibility: Policy and Procedure

_____I understand I am financially responsible should I request any of the following additional fees from Dragonfly Center for Counseling or my therapist:

- GROUP/WORKSHOP: varies by group
- PHONE/EMAIL: $1.10/minute over 10 minutes
- LETTERS FOR COURT/WORK/SCHOOL: $35.00/letter (72 hours notice required – does not include school/work excuse)
- COPY OF RECORDS: $50.00 for the first 25 pages, $1.00/page thereafter

Appointment Reservations: The therapy room is reserved specifically for you. Appointments are usually scheduled one time per week for approximately 40-45 minutes, with the initial session devoted to gathering all necessary information. The entire therapy process may take an average of eight to ten sessions.

_____ I understand that, if applicable, I will be charged a fee of $50.00 if **I do not show up for my appointment, make a same day cancellation for my appointment, make a same day cancellation with intention to reschedule, or if I am more than 15 minutes** late and Dragonfly Center for Counseling has already left the office.*

_____ I understand that it is acceptable to leave a voicemail or send an email for a cancellation notice in order to avoid a no show fee. If I am running late I can make a courtesy call to my therapist or Dragonfly Center for Counseling. Acceptable phone numbers and email addresses are:

- Amanda Brinkmeyer– Phone: (832) 821-5819 (Texting Available)
- Email: amanda@dragonflycfc.com

_____ I understand that if I reschedule, cancel, or no show my appointment 3 times in a row that I must pre-pay at the rate listed above prior to making any future appointments. No refunds will be given if pre-pay appointments are cancelled or missed.

_____ I understand that all fees due are to be paid at the time services are rendered. Advanced payments are to be used within 2 weeks of payment date. No refunds on services or advanced payments, including clients on a prepay plan.

_____ I understand that a $25.00 fee will be charged at or before the next session for returned checks or declined/ invalid credit cards in addition to session fees due. If fee is unable to be charged, an invoice will be mailed to the address listed on page 1 of this form. I also understand that I am responsible for any additional fees incurred by Dragonfly Center for Counseling for any disputed credit card charges. Prior to disputing credit card charges from me, please discuss the charges with your therapist in order to avoid these fees.

_____ I understand that my client file will be closed after a 30 day lapse in services. When I return I understand my fee will be at the current, standard rate or private pay discount rate.

_____ I understand that Dragonfly Center for Counseling, PLLC, its employees, owners & officers shall not be liable for any injuries or damages incurred by the undersigned for active or passive negligence caused by a clinician, the undersigned hereby indemnifies and holds harmless Dragonfly Center for Counseling, PLLC or its location affiliates from any and all claims, damages, injuries of whatever nature that may be caused by a clinician, the facility or facility staff of any program or location.

I acknowledge that I have read this document in its entirety and understand the above policy information regarding services provided, client rights, and limits of confidentiality. I understand and accept the Financial Responsibility & Appointment Cancellation Policy Statement. I also acknowledge my review of HIPPA.

_____ _____

Client (or guardian) Signature Date

_____ _____

(Amanda Brinkmeyer, M.Ed, LPC, NCC) Signature Date

Insurance Information

Name of insurance company: _____

Phone Number of Insurance (Listed on the back of the card) _____

ID # _____ Group # _____

Insured's Name: _____

Patient's Relationship to Insured: _____

Insured's Address: _____

City: _____ State: _____ Zip: _____

Insured's Date of Birth: _____ Insured's Gender: _____

Insured's Employer: _____

I give Dragonfly Center for Counseling, PLLC permission to bill my insurance for services rendered.

_____

Printed Name

_____ _____

Signature Date

Behavioral Health/Medical Provider Coordination of Care

Please complete this form so we may communicate with your Primary Care Physician or other medical provider. If you do not have a physician, or do not want to disclose information to any medical provider, please check the appropriate box at the bottom and sign.

CLIENT INFORMATION

Client's name (person being seen for counseling):	Birthdate:	Age:
If client is a minor, parent's or guardian's name:		Daytime phone no:
Client's home address:		

Client Authorization:
I understand that I am not required to sign this authorization as a condition of receiving services from Dragonfly Center for Counseling. The reason for disclosure is to facilitate continuity and coordination of treatment and may include the diagnosis of mental health disorders. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. In any event, this consent shall expire one (1) year from the date signed unless revoked earlier. **Expiration date**: _____

PRIMAY CARE PHYSICIAN OR MEDICAL PROVIDER

_____ Client does not have a medical provider.

PCP or Medical Provider:	PCP or Medical Provider phone no:
PCP or Medical Provider Address:	PCP or Medical Provider fax no:

I give my authorization (check all that apply):

_____ To release any applicable mental health information to my PCP and/or medical provider designated above.

_____ To release any applicable medical information from my PCP and/or medical provider to my behavioral health provider.

I DO NOT give my authorization:

_____ To release any information to my PCP and/or medical provider.

Client Signature: _____ Date: _____

Pre-Authorization Charge Form

If you plan on using your insurance plan, please recognize that submission of claims to your insurance company is done as a service to you. Co-payments or deductibles are payable at the time of service. Dragonfly Center for Counseling will diligently attempt to be reimbursed from your insurance. In the event the claim is denied and insurance does not pay for your session(s), you are ultimately responsible for the balance on your account.

I authorize Dragonfly Center for Counseling, PLLC to keep my signature on file and to charge my credit card listed below for the following:

- Any balance due that was not paid by my insurance company. _____ (Initial)

- $50.00 for missed appointments and same-day cancellations. _____ (Initial)

I understand that this form is valid for one year unless I cancel the authorization through written notice to the service provider.

Client's Name: _____

Client's Signature: _____

Date: _____

Card Type: _____

Name on Card: _____

Card Number: _____

Expiration Date: _____

CVV Code (usually found on the back of your card) _____

Dragonfly Center for Counseling is in compliance with HIPPA standards and policies. All of your information is stored in a secure area.

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Recordings and Electronic Device Policy
(Minor & Parent Agreement)

- Dragonfly Center for Counseling, PLLC does not give permission to record (voice or video) any therapeutic sessions, phone calls or consultations.

- This policy is to ensure the integrity of the therapeutic process as well as maintaining HIPAA compliance.

* I, _____ parent/guardian to _____ have reviewed and understand Dragonfly Center for Counseling, PLLC policy for recordings and electronic devices.

_____ _____
Signature Date

* I, _____ parent/guardian to _____ have reviewed and understand Dragonfly Center for Counseling, PLLC policy for recordings and electronic devices.

_____ _____
Signature Date

* I, _____ (minor client) have reviewed and understand Dragonfly Center for Counseling, PLLC policy for recordings and electronic devices.

_____ _____
Signature Date

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CKAM Procedures

(Communication Knowledge And Monitoring)

1. Upon making an appointment for therapy, it should be communicated clearly that the custodial parent(s) MUST be present for the intake session.

If the custodial parent(s) is/are unable to attend the intake session, attendance via phone, or video chat is acceptable)*

2. Topics that should be covered during the intake session:
    1. Role of therapist, client, and parent(s)
    2. Confidentiality and how this applies/does not apply to minors
    3. Organization of therapeutic environment (treatment style of therapist)
    4. Presentation and review of proposed treatment plan
    5. Emergencies - Communication will be returned outside of business hours if the client is in emotional crisis.

Dragonflycfc considers an emotional crisis to be one of extreme panic, extreme life event, or an extreme low in depression.**If the client is experiencing suicidal or homicidal ideation, 911 is the appropriate contact.

    6. Acceptable methods of communication outside of session include:

        1. Phone calls (<15 minutes) > 15 minutes will result in a $25 fee for time.
        2. Text message (response time - within 4 hours of received message, or the following business day depending on the time of day the message was sent)
        3. Email - Communication regarding scheduling or administrative questions are appropriate for email. Any communication beyond that should be via phone or through an in-person consultation (no less than 15 minutes)

    **All methods of communication will be returned during business hours (Tues-Thurs 9-6), or within 24 hours of receiving the communication* (During the business week: Monday-Friday)*

3. BOTH custodial parents will meet with therapist at least once per month to discuss progression of treatment plan, or to make known adjustments to the treatment plan.

*If all custodial parent(s) are unable to attend this consultation session, attendance via phone, or face time is acceptable)

I _____, parent/guardian of _____ have received and understand the CKAM procedures for therapy at Dragonfly Center for Counseling.

_____ _____

Signature Date

_____

Printed Name