LINDSAY SORENSEN, M.S., LPC-S, LCDC

855 Texas Street • Fort Worth, Texas 76102 • (817) 714-5226 • counseling@lindsaysorensen.com

CLIENT INFORMATION

Office use only:__________ Date:________________

Client Name:______________________________ Age:______ Date of Birth:________________

Gender:__________________________ Race/Ethnicity:____

Relationship Status:_________________ Partner's Name (if applicable):__________________________

List all members of your live-in family and their ages: ____

____

Client Address:____

Preferred Phone #: (____) __________________ Okay to leave message? Yes______ No______

Alternate Phone #: (____) __________________ Okay to leave message? Yes______ No______

Email Address:______________________________________ Okay to email? Yes______ No______

Financial Guarantor: ☐ Client is financial guarantor (If so, skip to the next section.)

Name:____ Relationship to client:___________________

Date of Birth:________________ Address:____

Preferred Phone #: (____) __________________ Okay to leave message? Yes______ No______

Emergency Contact:

Name of contact person:___________________________ Relationship to client:___________________

Preferred Phone #: (____) __________________ Okay to leave message? Yes______ No______

Alternate Phone #: (____) __________________ Okay to leave message? Yes______ No______

Referral Information:

Who referred you? ____

If you were not referred, how did you hear about Lindsay?_____________________________________

If Client is a Minor: (If client is an adult, skip to the next section)

Mother's Name: ____

Preferred Phone #: (____) __________________ Okay to leave message? Yes______ No______

Address: ____

Father's Name: ____

Preferred Phone #: (____) __________________ Okay to leave message? Yes______ No______

Address: ____

If parents are divorced/ separated, which parent has legal custody of this child? _____________________

Do both parents have legal authorization regarding medical/ counseling decisions for this child?________

If not, please explain: ____

<u>REQUIRED</u>: CREDIT CARD INFORMATION TO BE KEPT ON FILE

Your credit card information will be kept confidential, and only Lindsay will have access to it. It will only be used in the following situations:

- No-shows or appointments cancelled with less than 24 hours notice
- Returned check fees
- Minors or adult children driving themselves to appointments without payment
- Outstanding balances
- Court appearances, depositions, special reports/letters, or phone consultations
- After-hours emergency calls requiring Lindsay's assistance

All of the following fields must be completed. Please write clearly.

Credit Card Type (circle one): Visa MasterCard American Express Discover

Name as it appears on card:____

Credit Card Number:____

Exp. Date:__________________ Billing Zip Code:__________________

Security Code/CVV:__________ (Last 3 digits on back of Visa/MC/Discover; extra 4 digits on front of AmEx.)

I authorize Lindsay Sorensen Counseling, PLLC to charge my credit card for the amount due for services listed above, which are further outlined in the **"Professional Disclosure Statement;"** ***or for the balance of my account if not paid in full. If I do not accompany my minor or adult child to the appointment, I understand Lindsay Sorensen Counseling, PLLC will bill my credit card under the assumption my child has the authority to authorize payment.***

____ ________________________

Cardholder/Financial Guarantor Signature Date

____

Cardholder/Financial Guarantor Printed Name

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CHILD/ADOLESCENT BACKGROUND INFORMATION

Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. It is generally beneficial for your adolescent to assist you in completing this form.

Child's Name: ___________________________________ Date of Birth:________________

Completed by:___________________________________ Relationship to Child:__________

YOUR CURRENT CONCERNS:

Describe what led to your calling a counselor and what you hope your child gets from counseling:
____
____

Is your child currently having suicidal thoughts or urges? Yes / No

Has your child ever attempted suicide? Yes / No If yes, when? ______________________________

PHYSICAL HEALTH:

How is your child's physical health? Poor__ Unsatisfactory__ Satisfactory__ Good__ Very good__

Approximate date of last physical and name of doctor/clinic: _________________________________
____

Please list any persistent health concerns (chronic pain, headaches, diabetes, etc.): _______________
____

Medications your child is now taking (list daily dosage and frequency):________________________
____

PREVIOUS COUNSELING/ PSYCHOLOGICAL TESTING:

Please list counselors your child has seen before: Name, phone, dates, reason for seeing. Start with the most recent and work backward. Also list any psychological testing your child has had done:
____
____

SOCIAL:

What does your child do for fun? How many times per week? ________________________________

How many hours of "screen time" per week (T.V., video games, smart phones, tablets, etc.)?_______

What kind of religion, if any, does your family practice?_____________________________________

Does your child have an after-school job? Yes / No If yes, where? ___________________________

SCHOOL:

What grade is your child in?____

Is your child struggling with grades or attendance? ____

Has your child been diagnosed with a learning disability?____________________________________

Please list any behavioral issues your child has had in school:__________________________________
____

Please list any other concerns you have about your child related to school:_____________________
____

LEGAL:

List dates and reasons for any arrests/criminal charges/convictions, including DWI: ______________
____

Has your child ever been sent to juvenile detention? ____

Is this child involved in a custody dispute? Yes / No If yes, is it hostile or friendly?_____________

SUBSTANCE USE:

List most recent use of each and how often it is used:

Tobacco: ____
Alcohol:____
Marijuana:____
Other (specify):____

Does your child suffer from any addictions (substances, behaviors, etc.): Yes / No If yes, describe:
____

If your child has been through chemical dependency treatment, please list when and where:
____

Please describe any concerns you have about your child related to substance use: ________________
____

LIVING SITUATION:

Describe where your child lives, how long he/she has lived there, what the neighborhood is like:
____
____

List name, relationship to child, and age of the people your child lives with:____________________
____
____

If parents are divorced/separated, how often does the child see the non-custodial parent? __________

Is your household: Very lenient__ Somewhat lenient__ Average__ Somewhat strict__ Very strict__

CURRENT CONCERNS:

Indicate any concerns you currently have regarding your child:

___Adjustment to life changes (changing schools, parents divorcing, moving, etc.)
___Bed wetting, daytime wetting, soiling or related problems
___Abuse (physical, emotional, sexual)
___Disturbing memories (past abuse, neglect, or other traumatic experience)
___Drug or alcohol use (both legal and illegal drugs)
___Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
___Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, etc.)
___Feeling angry or irritable
___Feeling guilty or shameful
___Feeling grief-related sadness or depression
___Feeling sadness or depression NOT related to grief
___Gang-related concerns
___Health concerns (physical complaints and/or medical problems)
___Illegal behaviors (running away, stealing, fire setting, truancy, etc.)
___Learning/academic difficulties
___LGBTQ-related concerns
___Personal growth (no specific problem)
___Parent-child relationship (discipline, adoption, single parent, etc.)
___Family or step-family relationship problems
___Non-family relationship problems (teachers, peers, etc.)
___Religious or spiritual concerns
___Sexual concerns (excessive masturbation, inappropriate acting out)
___Sleep problem (nightmares, sleeping too much or too little, etc.)
___Speech problem (not talking, stuttering, etc.)
___Suicidal ideation (thoughts of death, wanting to die)
___Self-harm behavior (cutting, other self-harm, without intent to die)
___Unusual experiences (loss of periods of time, sensing unreal things, etc.)
___Unusual behavior (bizarre actions, compulsive behavior, tics, motor behavior problems, etc.)
___Other (explain:____)

Please circle the most significant issue above.

When did you first become concerned about this issue?

____

How have you attempted before now to deal with this issue?

____

Describe the first, perhaps very small, signs that tell you things are improving:

____

ADDITIONAL COMMENTS:

Please include any comments or additional information you would like to add:

____
____
____
____
____

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PROFESSIONAL DISCLOSURE STATEMENT

My Credentials

I am licensed to practice independently and without restrictions in the state of Texas. My credentials are:

- Master of Science in Counseling Psychology from Tarleton State University
- Bachelor of Science in Psychology and Criminal Justice from Texas Christian University
- Licensed Professional Counselor- Supervisor (LPC-S)
- Licensed Chemical Dependency Counselor (LCDC)
- EMDRIA-approved provider of EMDR therapy
- Certified Prevention Specialist (CPS)
- Nationally Certified Pharmacy Technician

Counseling Purposes, Goals, and Risks

The purpose of counseling is to enhance your personal growth and your ability to cope with life's problems. By helping clients learn to identify, evaluate, and change unhealthy thinking patterns, therapeutic changes in mood and behavior can occur. I am trained in a variety of counseling approaches, including client-centered, cognitive-behavioral, and EMDR, among others. Your specific goals will be discussed in session, and a treatment plan will be developed. While benefits are expected from counseling, progress may vary and is not guaranteed, as it is often dependent upon a variety of factors, including support systems, clients' readiness to address certain concerns and/or follow through with between-session assignments. The risks associated with counseling include discomfort related to making changes, or talking about difficult memories or concerns.

Confidentiality

I am required to keep confidential the fact that you are my client and anything that happens in your counseling sessions. If you give me written permission to exchange information with another person or agency, then I may do so. A few situations create exceptions to the standard of confidentiality, including:

- Neglect/abuse of a child, vulnerable adult, or animal
- Imminent risk of suicide or homicide or physical harm to another
- A court order from a judge

Counseling Minor Clients

Please be aware that if you are bringing a minor for counseling or evaluation, you must have the legal (custodial) right to do so. If you do not have custody, you must let me know so that the appropriate consent for treatment may be obtained.

Just as with adults, most teens find it easier to talk openly about their lives when they feel safe and confident that their discussions will be kept confidential. Because it is often in the best interest of having a trusting therapeutic relationship with the child, I ask that you allow me to use clinical discretion when determining what to report to you. If I believe your child is at risk of harming him or herself or someone else, you will be notified right away and I will work closely with you to ensure your child's safety. If your child divulges any abuse or neglect has taken place, I will be required to notify the appropriate authorities. In almost all other circumstances, however, it is most beneficial to your child's progress for you to allow me to maintain his or her confidentiality. Please discuss with me prior to the first session any concerns you have about this.
If your adolescent or adult child arrives for their session unaccompanied by an adult/guarantor, please send payment with them. It will be assumed he or she has the authority to authorize payment from your on-file

credit card, as well as the authority to schedule the next appointment, for which the guarantor will be responsible. ✤**INITIAL________**

Plan for Records

I will keep your records for 5 years after therapy ends. In the event of my death or incapacity, or the termination of my counseling practice, all records will be transferred to Tempa Sherrill, LPC-S.

Fees, Payments, and Cancellations

Session fees
My standard rate is **$125 per 50 minute session** for adolescents, adults, couples, or families. Extended 75-minute sessions and brief 35-minute sessions are available; rate is adjusted accordingly.

Payments
I accept cash, check, and all major credit cards, including HSA debit cards that display the Visa or MasterCard logo. Payment is due at the beginning of each session.

Cancellations
No-shows or sessions cancelled within 24 hours prior to the scheduled appointment time will be subject to a charge equal to the full session rate. This fee will be billed to your on-file credit card. ✤**INITIAL________**

Additional fees
Special reports, letters, or phone consultations will be billed at a rate of $35 per 15 minutes. For court or deposition time, a fee of $150 per hour will be required. For copies of your records, a fee of $25 per chart will be required. These fees will be billed to your on-file credit card.

Health Insurance Coverage

Insurance is not accepted. You can, however, request reimbursement from your insurance company, as some carriers do offer some coverage for out-of-network providers. It is advisable to determine exactly what is covered, how many sessions are allowed, and any limitations regarding the reasons for counseling. I am not responsible for the outcome with your insurance company. You are solely and completely responsible for paying for all services rendered at the time they are rendered.

Mental Health Crisis/ Emergency Availability

I do not provide 24-hour coverage. If you are in a mental health crisis situation or other emergency scenario, please call 911. You may call me at (817) 714-5226, but please understand I cannot guarantee an immediate response. You are responsible for getting your crisis needs met without my assistance if necessary.

CLIENT ACKNOWLEDGEMENT OF INFORMATION

Your signature below indicates that you have read, understood, and agree to the above policies. This signature also demonstrates that you have the legal authority to consent to treatment (i.e. are either above the age of 18, or are the legal/custodial parent if the client is a minor).

✤_______________________________________ ________________________
Client Signature (or Parent/Guardian if Client is a Minor) Date

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. It also serves to obtain your consent for policies and procedures. Please review it carefully.

Effective November 1, 2015:

Lindsay Sorensen Counseling, PLLC is required by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) to provide confidentiality for all Protected Health Information in our possession. Information is only released in accordance with state and federal laws and the ethics of the counseling profession. This Notice is to inform you of the uses and disclosures of information that may be made by the practice, and the practice's legal duties with respect to confidential information.

Use and disclosure of protected health information for the purposes of providing services:
Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes only:

- **Treatment:** providing, coordinating, or managing mental healthcare and related services. For example, use or disclosure in the process of giving or receiving a referral for services.
- **Payment:** activities such as obtaining payment for the mental healthcare services provided. For example, processing your form of payment (i.e. check or credit card).
- **Healthcare Operations:** the business aspects of running the practice. For example, to evaluate our treatment and services while caring for you.
- **Other Uses and Disclosures without your consent:** as listed below.

Uses and Disclosures with Neither Consent nor Authorization:
Lindsay Sorensen Counseling, PLLC may use or disclose your mental health information without your consent or authorization in the following circumstances:

- **Abuse:** If we have reason to believe that a minor child, elderly person or person with a disability has been abused, abandoned, or neglected, we must report this concern to the appropriate authorities.
- **Health Oversight Activities:** If the State Board is investigating a clinician that you have filed a formal complaint against, we may be required to disclose protected health information regarding your case.
- **Judicial and Administrative Proceedings as Required:** If you are involved in a court proceeding and a court subpoenas information about the services provided to you and/or the records thereof; we may be compelled to provide the information. Although courts have recognized a clinician-client privilege, there may be circumstances in which a court would order the clinic to disclose personal health or treatment information.
- **Professional Harm:** If you disclose sexual contact with another mental health professional with which you have had a professional relationship, we are required to report this violation to the licensing board. You have the right to anonymity in the filing of the report.
- **Serious Threat To Health or Safety:** If you communicate an explicit threat of imminent serious physical harm to yourself or others and we believe you may act on that threat, we have a legal duty to take the appropriate measures, including disclosing information to the police. In both cases, we will disclose only what we feel is the minimal amount of information necessary.
- **National Security:** We may be required to disclose personal information to military or federal authorities in instances where national security is concerned.

Please sign to indicate you understand our operational use of your information for treatment, payment, and healthcare operations as stated above.

____ ____________________
Client Signature (Or Parent/Guardian if client is a minor) Date

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INFORMED CONSENT

AND CONFIRMATION OF RECEIPT OF:

I) PROFESSIONAL DISCLOSURE STATEMENT
II) NOTICE OF PRIVACY PRACTICES

By your signature below, you are indicating 1) that you have received copies of Lindsay's *Professional Disclosure Statement* and the *Notice of Privacy Practices;* 2) that you voluntarily agree to receive mental health assessment and mental health care, treatment, or services, and that you authorize Lindsay to provide such services as considered necessary and advisable; 3) that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may at any time stop such services received through Lindsay; 4) that you have read and understood this statement and have had ample opportunity to ask questions about, and seek clarification of, anything that is unclear to you.

Release for Liability and Hold Harmless Provision: By signing this document, you are releasing Lindsay Sorensen Counseling, PLLC, and holding the practice harmless, from any personal liability that arises from departure from your right of confidentiality.

By my signature, I verify the accuracy of the *Notice of Privacy Practices, the Informed Consent* and my counselor's *Professional Disclosure Statement*, and I commit to conform to their specifications.

____ _________________________

Client's Signature Date

Informed Consent/ Confirm Receipt:

(To be signed by client and counselor at the beginning of the first session.)

_________________________________ ____________________

Client's Signature Date

_________________________________ ____________________

Counselor's Signature Date

If the client is a minor, please sign above AND below:

The legal guardian(s)/managing conservator(s) must sign the statement below:

If your conservatorship/guardianship is established by a divorce decree or custody document, you are required to provide a photocopy of the cause page (first page calling out the case), the page specifying conservator(s), and the signature page from the decree or document, before clinical services can begin.
With your signature(s) below, you affirm that you are the legal guardian(s)/managing conservator(s) of _____________________________ (minor's name). With an understanding of the above requirements, you grant permission for your child to participate in counseling and release the counselor from liability for same, as stated in the Release from Liability and Hold Harmless provision above.

____ _________________________

Legal Guardian #1 Signature Date

____ _________________________

Legal Guardian #2 Signature Date

L I N D S A Y   S O R E N S E N,   M . S .,   L P C - S,   L C D C

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E-MAIL AND TEXT MESSAGING INFORMED CONSENT

In order to communicate with you via e-mail or text message, Lindsay Sorensen Counseling, PLLC needs to ensure you are aware of the confidentiality and other issues that arise when communicating this way. This form is intended to document your understanding of these issues, and by signing, you are stating that you accept and agree to the following:

I understand that all e-mail messages are sent over the Internet, are not secure, and may be read by others. I understand that my e-mail communications with Lindsay will NOT be encrypted, and therefore Lindsay CANNOT guarantee the confidentiality or security of any information I send to her or that she sends to me via e-mail. I understand that text messages are no more secure than e-mail, and the same conditions apply.

I understand that for this reason Lindsay advises me not to send sensitive information via e-mail or text message. This includes information about current or past symptoms, conditions, or treatment, as well as identifying information such as social security numbers or credit card information.

I hereby give permission for Lindsay to reply to my messages via e-mail, including with any information that she deems appropriate, that would otherwise be considered confidential. I agree that Lindsay Sorensen Counseling, PLLC shall not be liable for any breach of confidentiality that may result from this use of e-mail via the Internet.

I understand that Lindsay will limit text messages to brief inquiries or responses regarding scheduling.

I understand that Lindsay may at times e-mail me information about resources that I can use as part of my treatment. I hereby consent to receive such information via e-mail.

I understand that e-mail and text message communication should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. I understand that if I use email or text messages to make or request scheduling changes, it is my responsibility to confirm that Lindsay has received my communication more than 24 hours before the appointment time that is being changed. If I believe I need a response within 48 hours, I will not use e-mail, but will instead call Lindsay by telephone. If I do not receive an answer to a routine e-mail or text message within two business days, I understand that I should call Lindsay by telephone.

I understand that all e-mail and text message communications may be made part of my permanent medical record, and would be accessible to anyone given access to those records. I also understand that I may withdraw permission for Lindsay to communicate with me via e-mail or text message by notifying her in writing.

____ ____________________

Client Signature (or Parent/Guardian if Client is a Minor) Date