Jaci Varnell, MS, LPC
6401 Eldorado Pkwy, Suite 302
Mckinney, TX 75070
(214)924-4511

Adult Intake Form

Date_____ Referral Source_____

Client Name_____

Date of Birth _____ Age _____

Address _____

Street City/State Zip Code

Home Phone _____ Permission to leave message _____

Cell Phone _____ Permission to leave message _____

Which number would you prefer to be contacted by? _____

Email Address_____

Place of Employment/job title_____

Marital Status __Married __Separated __Divorced __Remarried __Never Married

In case of emergency, I authorize Jaci Varnell, LPC to contact:

_____

Name Phone Relationship to Child

Medical Information

Current Medical Conditions_____

Past Medical Conditions_____

Medications currently taking_____

Have you ever seen a counselor/psychologist/psychiatrist or been evaluated for psychiatric treatment? If so, please explain.

_____
_____
_____
_____

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Household

Please list the people currently living in the household

Name Relationship to Client Age

_____
_____
_____
_____
_____
_____
_____

Intake

What is your chief concern at this time? _____

_____

What if any stressful life events have recently occurred?_____

_____

What (if any) psychotropic medications are you taking or have you tried? _____

_____

What (if any) medications are you currently taking (please include vitamins and OTC)?
_____

List names and dates of counseling as well as problems addressed:_____

_____

Do you smoke? Y N Do you consume alcohol? Y N How many drinks per week? _____

Have you ever used an illegal substance or legal substance illegally? _____

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Symptom Checklist

Please check any symptoms that apply.

____decreased energy ___worthlessness ___hopelessess

____thoughts of not wanting to be alive ___suicidal thoughts

____negative thoughts ___withdrawal from others ___eating more/less

____sleeping more/less ____tearfulness ___detachment from feelings

____aggression ___excessive agitation ___feelings of guilt/shame

____self harm

____anxiousness ___panic attacks ___avoiding activities due to worries

_____ hair pulling ___skin picking ___lip chewing

____inability to concentrate ___constantly moving ___feeling as if run on a motor

____overwhelmed ___unable to complete tasks ___not wanting to be touched

____increased alcohol use ___increased spending

___difficulty making eye contact ____problems understanding social cues

___incongruent facial expressions to feelings ____sensitivity to noises

___sensitivity to touch ____sensitivity to light

___relationship difficulties ___academic difficulties __job difficulties

___parenting problems ___family problems

When would you estimate that these symptoms began? _____

Have you experienced similar symptoms before? _____When? _____

What have you tried that has made the symptoms better/worse? _____

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CONSENT FOR THIRD PARTY BILLING

If you choose to pay for therapy using a third party payer such as a community agency or insurance company, I will typically submit authorization and claims forms directly to them. **Third party payers typically do not cover fees for missed appointments, telephone consultations and certain other kinds of services.**
Please carefully review with your payer all information about amount and type of services they cover. If you have questions, please contact your payer. If you remain unclear about what is being provided, I will be glad to contact the payer and attempt to clarify the situation. It is particularly important to understand that third party payers may authorize payment for a specific number of sessions only or may require that I request their approval of additional sessions after an initial allocation. Third party payers may make their own decisions, independent of my recommendation, about how much or what kinds of treatment they will pay for or believe is necessary. Third party payers frequently require some information about your case when they agree to pay for treatment. Information required depends on the payer. Some examples of required information may include treatment attendance, or treatment information such as description of presenting problems, diagnosis, treatment type or plan, progress or treatment summary. You are welcome to discuss what is disclosed to payers with me at any time. Although community agencies or insurance companies are typically required to keep such information confidential, I have no control over what they do with this information once it is in their files.
By signing below, you agree to release all information necessary to the payer in order for me to obtain reimbursement for services, and you authorize direct payment to me by the payer. It is the client's responsibility to obtain authorization from any third party payer, prior to the first appointment**. Furthermore, the client is responsible for payment for all services rendered and charges incurred that are not covered by a third party payer.**
IF YOU WISH TO HAVE A THIRD PARTY BILLED PLEASE COMPLETE AND SIGN THE FOLLOWING:

Client Name _____ Date of Birth: _____

Insurance Company: _____

Insurance Group & ID# _____

Name of Insured Person:_____Date of Birth:_____

Address of Insured Person: _____

Employer of Insured Person: _____

_____ _____ _____
Client /(parent) Signature Date Parent's printed name

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HIPPA NOTICE OF PRIVACY PRACTICES

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

OUR LEGAL DUTY We are required by applicable federal and state law to maintain the privacy of your health information. We only release information in accordance with state and federal laws and ethics of the counseling profession. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of its Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change its Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice. This notice describes our policies related to the use and disclosure of your healthcare information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR THE PUPOSES OF PROVIDING SERVICES. We use and disclose health information about you for treatment, payment, and healthcare operations.
Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you to provide, manage or coordinate care, consultants, or referral sources.
Payment: We may use and disclose your health information to obtain payment for services we provide to you, verify insurance and coverage, and process claims.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, review of treatment procedures or business activities, certification, compliance activities, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up forms of health information.
Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.
Required By Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim, perpetrator or have knowledge concerning instances of abuse, neglect, domestic violence, or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient, under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text messages, electronic mails, postcards, or letters).
PATIENT RIGHTS Access: You have the right to look at or get copies of your health information, with limited exceptions. Counselors may deny this request. Counselors require a notice of at least two weeks to provide you with the requested information. We will charge you a reasonable fee for expenses such as copies and staff time. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before May 22, 2015. Exceptions: Disclosure for treatment, payment or healthcare operations, disclosures pursuant to a signed release, disclosure made to client, disclosures for national security or law enforcement. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Contact: You have to right to request where you would and would not like to be contacted.
Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). These requests must be in writing.
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances. If denied, you have the right to file a disagreement statement. Your disagreement statement will be filled in the record.
Electronic Notice: If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.
QUESTIONS AND COMPLAINTS If you want more information about our privacy practices or have questions or concerns, please contact us, using the contact information at the end of this Notice. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.
EFFECTIVE DATE, AND CHANGES TO PRIVACY POLICY
This was last updated on June 5, 2017 and will remain in effect until replaced.
You have the right to request to be notified of any future changes.

ANY PROBLEMS REGARDING ETHICAL QUESTIONS AND/OR CONCERNS MAY BE DIRECTED TO THE FOLLOWING CONSUMER HOTLINE:1(800) 942-5540

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Consent to Treatment

I am committed to providing high quality services to my clients and to providing them with all of the information necessary to be informed about the treatment process. As part of my effort in this regard, I am providing the following information about legal and ethical issues. If you agree to these stipulations, please sign the last page of this form. If you have questions, please discuss them with me before signing this consent.

Confidentiality

Confidentiality is described as keeping the information shared between a client and his/her therapist private. The following are possible situations that may limit confidentiality: a) Concerns that a client is a danger to himself/herself or someone else; b) The disclosure of abuse neglect, or exploitation of a child, elderly, or disabled person; c) The disclosure of sexual misconduct or unethical behavior of another mental health professional; d) Ordered by the court to disclose information; e) The client directs the release of information; or, f) Otherwise required by law to disclose information. In reference to the treatment of minors, risk-taking behavior that is considered detrimental to the safety of a minor or others will be shared with the minor's parent(s) and/or guardian.

Fees and insurance

The standard 55 minute individual session fee is $120.00 without insurance and the group session fee is $40.00. Co-payments will be accepted for clients with in-network insurance coverage according to their insurance and deductible plan. A sliding scale is offered. Payment is due at the time services are provided. You acknowledge that you are responsible for the cost of the provided services to you or your minor child and agree to pay them when billed or at the time of services, by consenting to treatment. In addition, there is a **$25 fee for telephone consultation with other professionals per your request.**

Insurance Consent

If you consent to utilize your insurance for counseling services, I will be asked to provide them with certain personal health information about you. This may include but is not necessarily limited to: a diagnosis, type and dates of service. By assigning benefits to Jaci Varnell, LPC you are authorizing me to provide your insurance carrier (or their intermediary) all personal health information necessary to process the claim. Please sign at the end of this consent to acknowledge that you understand and consent to the utilization of your insurance benefits and therefore acknowledge and consent to the release of your personal health information to the insurance carrier as requested.

Fees for Medical Records or Paperwork Provided at the Request of the Client

There is a $25 fee for each set of paperwork requested for the therapist to complete and provide.

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Appointments
If you need to cancel an appointment, 24-hours notice is required. If you miss an appointment without sufficient notification, you will be charged. Missed appointments **cannot** be filed with insurance. Therefore, you are responsible for a **$75 fee that will be charged to your credit card on file.** After two missed appointments that are not cancelled or rescheduled, you may be referred to seek therapy with another private therapist or agency.

Right to withdraw from treatment
If a conflict arises for a client or therapist, either has the right to withdraw from the treatment process. If I feel the need to withdraw from providing treatment, I will inform you and provide appropriate referrals.

Legal Actions
If legal actions occur in which I am requested to testify or am subpoenaed to provide testimony (such as in a custody or divorce case) you will be responsible to pay the following fees **regardless of if the subpoena is sent from the opposing side of the case or if the case never goes to court.** 1) All travel expenses; 2) A fee of $250 per hour from the time I leave the office until I return; 3) A fee of $250 per hour for preparation for testimony; 4) An initial fee of $2500 will be required at the onset of the legal action as a deposit for services. Any remaining balance will be returned when the case is settled. Record copying fees begin at $25.00.

Emergency Situations
In the unlikely event that as your therapist, in my clinical judgement, I believe you to be dangerous to yourself or to someone else, by signing this consent you authorize me to contact either persons listed as your emergency contacts, someone else, medical personnel or police to provide assistance through the crisis situation.

The Counseling Process
The therapeutic services provided by myself, Jaci Varnell, LPC, are clinical psychotherapy. Therefore, as your therapist, all contact with me will only take place in the context of the provision of a professional service. There will be an assessment phase, a treatment phase, and a termination phase to the process. In the assessment phase, I will talk with you to gain historical information and may request that you take some assessment instruments. I will discuss the result of any assessment with you. You will be encouraged to work to establish goals for your sessions. In the treatment phase, which will vary in length depending on the issues to be addressed, I will work with you using various methods to help you resolve the issues that brought you to treatment. In the termination phase, therapy will often be concluded by reviewing the completion of your therapeutic goals.

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Risks of Therapy
At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. It is extremely important and helpful for you to inform me, as soon as possible, of new problems or information that may have a positive or negative impact on you, your family, and/or your child.

After Hours
Please call 911 in an emergency. You may also call the Suicide and Crisis Center at any time at 214-828-1000. Calls to the office will be returned by the next business day with the exception of holidays and vacations.

Electronic Communication
It is against HIPAA standards for us to contact you electronically using text or email that is not encrypted. If you so choose to use this means of communication, I will not reveal or respond in any manner regarding counseling PHI (protected health information). Occasionally, I realize urgent matters arise and brief message sent by text or email regarding a scheduling issue may occur. Please understand that information exchanged this way is NOT protected.

If you have read and understand the aspects of this consent, please sign below to acknowledge your understanding and consent. You may request a copy of this consent to keep. If you have questions about any of the information on this form, please discuss them with me prior to signing the form. I look forward to working with you.

_____

Client Date

_____

Parent/Guardian (if applicable) Date

_____

Therapist Date

EFFECTIVE DATE, AND CHANGES TO CONSENT TO TREATMENT
This was last updated on August 2, 2017 and will remain in effect until replaced.
You have the right to request to be notified of any future changes.

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Credit Card Office Policy

This form authorizes Jaci Varnell, MS, LPC to keep my credit card on file and to manually charge the fee of service to this credit card number at the time services are rendered, or in the case of missed or late cancelled appointments. I understand I can choose an alternative form of payment at the time of service.

Name of Credit Card Holder: _____

Credit Card Number: _____

Type of Card: CREDIT or DEBIT

Expiration Date: _____Three Digit Code on Back of Card: _____

Billing Address: _____

_____

Authorized Cardholder's Signature: _____Date:_____

Please note, per the Client Information and Consent form, it is your responsibility to notify me **within 24 hours** to reschedule or cancel an appointment. It is my office policy to charge a fee of **$75.00** to your credit card for late cancellations and missed appointments.

I agree to this Credit Card Policy:

Printed Name _____ Date_____

Signature of Client or Parent/Guardian if Client is a Minor: _____

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Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit **www.therapyappointment.com** to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system.

Client's name: _____

Your email address: _____

Your cell phone number: _____

Where would you like to receive appointment reminders? (check one)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ Via an automated telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own.

(Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

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Signature Date