TOTAL LIFE COUNSELING

SERVING DALLAS & the LONE STAR STATE

WELCOME PACK

CLIENT INTAKE, INFORMATION, FORMS & RELEASES

ADULTS

NEW CLIENT WELCOME

Congratulations. Here are your first steps.

TOTAL LIFE COUNSELING / COACHING / COMMUNICATION DALLAS

KEEP IN MIND…

The hardest step with counseling is making the first appointment and you did it!

To ensure you properly navigate your engagement with Total Life Dallas, here are a few recommendations to keep your momentum so you can maximize your benefits from coaching or counseling:

1 **Financial Concerns**

If there are any financial issues or concerns we may be able to work with you on this.

2 **Calendar**

Always remember to have your calendar when you come to TLC and when you call to reschedule.

3 **Save time**

Having your calendar will save you time and keep you from needing to remember to call us back

4 **Life get busy**

Often people forget to call back to reschedule or schedule a follow-up appointment

5 **Consistency**

Follow-up appointments are important in order to receive the maximum benefits from your first session!

6 **Canceling & Rescheduling**

If you do not receive a reminder call please keep in mind the reminder is a courtesy but we need to leave it up to you to contact us at least two (2) business day prior to your appointment time if you need to reschedule

7 **Expectations**

Everyone has their own idea of what to expect from counseling varying from watching Dr. Phil or prior experiences. Please discuss your feelings if you feel your expectations are not being met. We can usually address this concern right away.

8 **Closure**

When things are going well often clients cancel their appointment before letting us know about their progress. We love to hear the good news so it's very important to have that final session to celebrate your counselor!

Office: 1500 Dragon Street, Suite 160, Dallas, Texas 75207
Phone: 469.757.5215

SERVICING TEXAS WITH HQ IN DALLAS

TLC | Dallas Telehealth services available throughout Texas!

Select your choice of Licensed Counselors or Life Coach professionals

Access your therapy online or face-to-face (Dallas only)

Work through life's challenges with real-world action plans that build your life's vision while positioning you for success.

Access therapy online from anywhere in the State of Texas!

VIRTUAL / IN-PERSON (DALLAS)

VIRTUAL IN TEXAS

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DALLAS

STATE OF TEXAS

CONTACT US

Access Help & Resources

You should always get the help and resources you need. This is important contact information and resource lines

Our Address	1500 Dragon St, Ste 160, Dallas, TX 75207
Phone & Email	469.757.5215 Info@TotalLifeCounseling.com
Immediate Help & Emergency	911 Emergency 988 National Suicide Prevention Hotline

Individual, Family, Marriage & Group Counseling
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F: 407-248-0226
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GENERAL INFORMATION

Date : _____ How did you hear about us? _____

Full Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. _____

Name You Prefer:_____ Age : _____ Date of Birth): _____

Sex: ☐ Male ☐ Female Other:_____

Race: ☐ White ☐ Black ☐Hispanic ☐ Asian ☐ Other: _____

CONTACT INFORMATION

Street Address: _____ Suite/Apartment Number: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: ☐ Yes ☐ No

Home Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Mobile Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Email Address: _____ May We Send Email Here: ☐ Yes ☐ No

I would like to be added to Total Life Counseling Newsletter to receive free articles, tips and resources: ☐ Yes ☐ No

I prefer to be ☐ texted ☐ emailed ☐ phone call ☐ none for appointment reminders.

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

Average Annual Salary: ☐ $0 to $10,000 ☐ $10,001 to $20,000 ☐ $20,001 to $40,000 ☐ $40,001 to $50,000 ☐ $50,001 to $60,000 ☐ $60,001 to $80,000 ☐ $80,001 to $100,000 ☐ More than $100,000

EDUCATION INFORMATION

Last Year of School Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

Are You Currently in School: ☐ Yes ☐ No. If Yes, What School: _____

RELATIONAL INFORMATION

Current Relational Status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Content with Your Current Status: ☐ Yes ☐ No. If No, Briefly Explain: _____

If Married, How Long: _____Number of Previous Marriages for You: _____ For Your Partner: _____

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If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

Partner's Name: ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. _____

How Long Have You Known Your Partner: _____ Age: _____ Preferred Name: _____

Partner's Race: ☐White ☐Black ☐Hispanic ☐ Asian ☐ Other: _____ Partner's Sex: ☐ Male ☐ Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: ☐9 ☐10 ☐11 ☐12 ☐GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: ☐ Yes ☐ No ☐ Unsure ☐ Partner Doesn't Know

With Whom Do You Currently Live (*Check All that Apply*): ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s) ☐ Sibling(s) ☐ Boyfriend ☐ Girlfriend ☐ Roommate ☐ Other: _____

CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Biological, Adopted, Step)*	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: ☐ Yes ☐ No. If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: ☐ Yes ☐ No. If Yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Mom, Dad, Sibling,Step)*	Occupation	Describe Him/Her

Do You Have a Personal Support System: ☐ Yes ☐ No. If Yes, Who: _____

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MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Specialty *(e.g. Family Practice, OB/GYN, Internal Medicine)*: _____

Are You Currently Receiving Medical Treatment: ☐ Yes ☐ No. If Yes, Please Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had *(Use Back if Necessary):* _____

_____

MEDICATIONS

List All Current Medications You Are Taking, including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

Are You Taking these Medication(s) According to Your Doctor's Recommendations: ☐ Yes ☐ No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

Headaches.....	☐ Past	☐ Present	Dizziness.....	☐ Past	☐ Present	Stomach Trouble....	☐ Past	☐ Present
Visual Trouble.....	☐ Past	☐ Present	Sleep Trouble.....	☐ Past	☐ Present	Trouble Relaxing....	☐ Past	☐ Present
Weakness.....	☐ Past	☐ Present	Tension.....	☐ Past	☐ Present	Rapid Heart Rate...	☐ Past	☐ Present
Difficulty Breathing..	☐ Past	☐ Present	Intestinal Trouble....	☐ Past	☐ Present	Hearing Noises.....	☐ Past	☐ Present
Change in Appetite.	☐ Past	☐ Present	Tiredness.....	☐ Past	☐ Present	Pain.....	☐ Past	☐ Present
Hearing Voices.....	☐ Past	☐ Present	Seeing Things.....	☐ Past	☐ Present	Other.....	☐ Past	☐ Present

Your Height: _____ Your Weight: _____ How has Your Weight Change in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

Stress.....	☐ Past	☐ Present	Nervousness.....	☐ Past	☐ Present	Anxiety.....	☐ Past	☐ Present
Panic.....	☐ Past	☐ Present	Unhappiness.....	☐ Past	☐ Present	Depression.....	☐ Past	☐ Present
Guilt.....	☐ Past	☐ Present	Apathy.....	☐ Past	☐ Present	Terminal Illness.....	☐ Past	☐ Present
Recent Death.....	☐ Past	☐ Present	Grief.....	☐ Past	☐ Present	Hopelessness.....	☐ Past	☐ Present
Inferiority Feelings..	☐ Past	☐ Present	Defective Feelings..	☐ Past	☐ Present	Loneliness.....	☐ Past	☐ Present
Shyness.....	☐ Past	☐ Present	Fears.....	☐ Past	☐ Present	Friends.....	☐ Past	☐ Present
Marriage.....	☐ Past	☐ Present	Communication.....	☐ Past	☐ Present	Physical Abuse.....	☐ Past	☐ Present
Emotional Abuse....	☐ Past	☐ Present	Verbal Abuse.....	☐ Past	☐ Present	Sexual Abuse.....	☐ Past	☐ Present
Temper.....	☐ Past	☐ Present	Anger.....	☐ Past	☐ Present	Aggressiveness.....	☐ Past	☐ Present
Bad Dreams.....	☐ Past	☐ Present	Concentration.....	☐ Past	☐ Present	Racing Thoughts....	☐ Past	☐ Present
Unwanted Thoughts	☐ Past	☐ Present	Memory.....	☐ Past	☐ Present	Loss of Control.....	☐ Past	☐ Present
Impulsive Behavior.	☐ Past	☐ Present	Self-Control.....	☐ Past	☐ Present	Compulsivity.....	☐ Past	☐ Present
Sexual Problems....	☐ Past	☐ Present	Pregnancy.....	☐ Past	☐ Present	Abortion.....	☐ Past	☐ Present
Legal Matters.....	☐ Past	☐ Present	Trauma.....	☐ Past	☐ Present	Eating Problems....	☐ Past	☐ Present
Drug Use.....	☐ Past	☐ Present	Alcohol Use.....	☐ Past	☐ Present	Trouble with Job.....	☐ Past	☐ Present
Career Choices.....	☐ Past	☐ Present	Ambition.....	☐ Past	☐ Present	Making Decisions...	☐ Past	☐ Present
Children.....	☐ Past	☐ Present	Being a Parent.....	☐ Past	☐ Present	Finances.....	☐ Past	☐ Present
Recent Loss.....	☐ Past	☐ Present	Disaster.....	☐ Past	☐ Present	Smoke Cigarettes...	☐ Past	☐ Present

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LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below *(1 = Very Little Distress; 10 = Extreme Distress)*:

1 2 3 4 5 6 7 8 9 10

Are You Currently Experiencing Any Suicidal Thoughts: ☐ Yes ☐ No. Have You Experienced Them in the Past: ☐ Yes ☐ No

Have You Ever Attempted Suicide: ☐ Yes ☐ No. If Yes, When and How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: ☐ Yes ☐ No

If Yes, When and Who: _____

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling *(i.e. What Are Your Issues, Problems?):* _____

_____

Why Have You Decided to Come for Counseling Now: _____

_____

What Do You Hope to Gain or Change by Coming for Counseling: _____

_____

How Long Do You Believe Counseling Should Last: _____

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received *(Use Back If Necessary):*

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

RELIGIOUS BACKGROUND

Please describe your religious involvement if any. Are there any special religious, cultural or ethnic considerations we should be aware of?

_____

ACTIVITIES, INTERESTS, & STRENGTHS

What do you do in your spare time? _____

What do you do well? _____

TERMS OF SERVICE

I hereby give Total Life Counseling Center permission to provide counseling services for the client mentioned above:

Signed: _____ Date: _____

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Victimization History

Abuse:
Physical:

_____
_____

Sexual:

_____
_____

Mental:

_____
_____

Neglect:

_____
_____

Domestic Violence:

_____
_____

Past C.P.S. Involvement:

_____
_____

Potentially Abusive Behavior:

Substance	Onset	Current	Highest	Most Recent	Tolerance/Withdrawal
Alcohol					
Marijuana					
Cocaine					
Depressants					
Amphetamines					
Hallucinogens					
Opiates					
Inhalants					
K2, Bath salts, spice					
Other					
Tobacco					
Caffeine					

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Authorization of Release Form

Our therapists may find it helpful to consult with your attorney, doctor, school, or applicable parties regarding treatment. In order to consult we need your authorization. If applicable, please complete on for each contact.

I, _____, hereby authorize Total Life Counseling Center, Main Office at 1507 S. Hiawassee Road, Orlando, FL 32835 to:

Release information of: _____ _____
Name of Client Date of Birth

To/From: (family, doctors, psychologist, schools, etc.) _____

_____

Phone #/Email: _____

(Please specify if you only want to authorize for appointments and payments.)

For the purpose of: ☐ Outpatient/Inpatient Counseling ☐ Coordination with schools
☐ Coordination with MD/Psychologist/OT Therapist/Therapist
☐ Coordination with other family members

I understand that under state and federal confidentiality provisions only the above specified information can be released to only the above specified person or agency. I also understand that I may revoke this release of information at any time, providing that I notify the authorized agency in writing to this effect, but that revocation has no effect on action previously taken.

This consent will expire on (optional) _____

_____
Client, Parent, Guardian Date

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Financial Policy

Payment & Fee Policy:

We are committed to providing you with the best possible care. Payment for services is due at the time of service. We accept cash, checks, Master Card, and Visa. Our fees:

- Individual, Family and Marriage Sessions : Clients are financially responsible for their counseling sessions. And there is a $5 per hour cash or check discount effective September 1st, 2012.
- Payment methods: Checks and cash must be received before the session if sent via mail. If payment has not been received, the session must be rescheduled.
- Counselor Administrative Services: Treatment Summary Requests, Professional Letters, and Phone/Conference calls will be billed, if requested, at the individual therapeutic rate for a minimum of 30 minutes.
- Court Appearances and Depositions are double the therapeutic hourly rate. This would include travel expenses and time away for the office. Payment is to be made in advanced and any unused funds will be refunded. The retainer is a minimum of 4 hours and we will need a credit card on file in the event the court hearing goes over.
- A cancellation fee is charged for appointments with **credit/debit** only that are no show or canceled without **2-business days** advance notice unless there is an emergency or illness. The no–show fee is equivalent to your normal session fee.
- Returned checks are subject to a $42 fee
- If a patient's appointments are being covered by PIP, we must have a credit card on file in the event that your claims are denied or benefits are exhausted. Please note that any charges not covered by the third party will be the patient's responsibility.

Disclosure:

Please be aware if for any reason we do not receive payment, your information may be used during a debt collection.

To secure your appointments, please enter credit card information below. This is a different requirement from the card used to hold initial appointment.

I authorize TLC to place my credit card information on file to charge for any applicable/outstanding fees.

(required) CC #_____ Exp:_____ CVC:_____

Policy on Insurance Reimbursement:

If you have medical Insurance that provides coverage for mental health counseling, we want to help you receive your maximum allowable benefits. We will be happy to help you process your insurance claim form for your reimbursement. A completed insurance form must accompany any such request at each visit. You are responsible for mailing it to the insurance company and tracking your reimbursement. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, called "Usual, Customary and Reasonable" (UCR).
   Some companies pay a percentage of the UCR for a given area. However, some companies reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If your company requests a report from us in order to process your claim, we will need to receive our normal hourly fee from you for this service.
5. I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my health insurance.

By signing below I agree to the terms listed above.

Signature _____ Date _____

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Please do not write in space below. For office use only

Issues	Descriptions & Objectives	Interventions

Diagnostic Impressions:

Axis I: _____

_____

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Informed Consent & Release of Liability

Name: (please print): _____

I understand the following:

1. Counseling services are provided by practitioners who have earned a Master's Degree, or higher, in the field of counseling from an accredited graduate program and who have been licensed by the state of Texas
    a. **Licensed Mental Health Counselors:** Jada Jackson, Helena Davis
    b. **Licensed Mental Health Counselor Associates**: Shermelia Drummer, Tracy Carey, Patricia Arps
    c. **Clinical Hypnotist:** Marina Sbrochi
1. Certified Life Coaches operate under the supervision of Dr. Jada Jackson, LMHC, LPC
    a. **Certified Life Coaches:** Natasha Gibson, Richard & Nancy Wallace, Stacye Bowers, Twyla Ellis
2. Although I expect benefits from this treatment, such benefits or particular outcomes cannot be guaranteed.
3. Due to the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing.
4. This counselor is not providing an emergency service; therefore, at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance.
5. Regular attendance will produce maximum results, but I am free to discontinue treatment at any time. A final closure/summary session is highly recommended to get the greatest benefits.
6. I understand that my counseling records & conversations with the counselor or coach are kept confidential, except where disclosure is required by law (i.e. abuse of a child, elderly or disable person; potential harm or threat to self or others and specific information subpoenaed by a court of law.)
7. I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.
8. I acknowledge that I may be given the option for telehealth when in-office sessions are not available and understand that it is my responsibility to make sure I maintain my own confidentiality while doing a virtual session.

All group members agree if the therapist is sued for breach of confidentiality, the client who breached confidentiality will hold the therapist harmless from any damages including attorney fees. Consequences of breaching confidentiality may result in pressed charges by another client. Although confidentiality agreements have been signed by all group members, this does not guarantee that confidentiality will not be breached by fellow group members.

My signature below indicated that I grant informed consent for Total Life Counseling to provide counseling services to myself and or minor members of my family.

Signature: _____ 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 about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

・*Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.

・*Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.

・*Health Care Operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

・The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

・The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

・The right to request an amendment to your PROTECTED HEALTH INFORMATION.

・The right to obtain a paper copy of this notice for us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
The Privacy Officer
Total Life Counseling
1507 S. Hiawassee Road #101
Orlando, FL 32835
(407) 248-0030

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877.696.6775 (toll-free)

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Acknowledgement of Receipt: Privacy Practice Notice

I,_____ have received a copy of Total Life Counseling Center Notice of Privacy Practices.

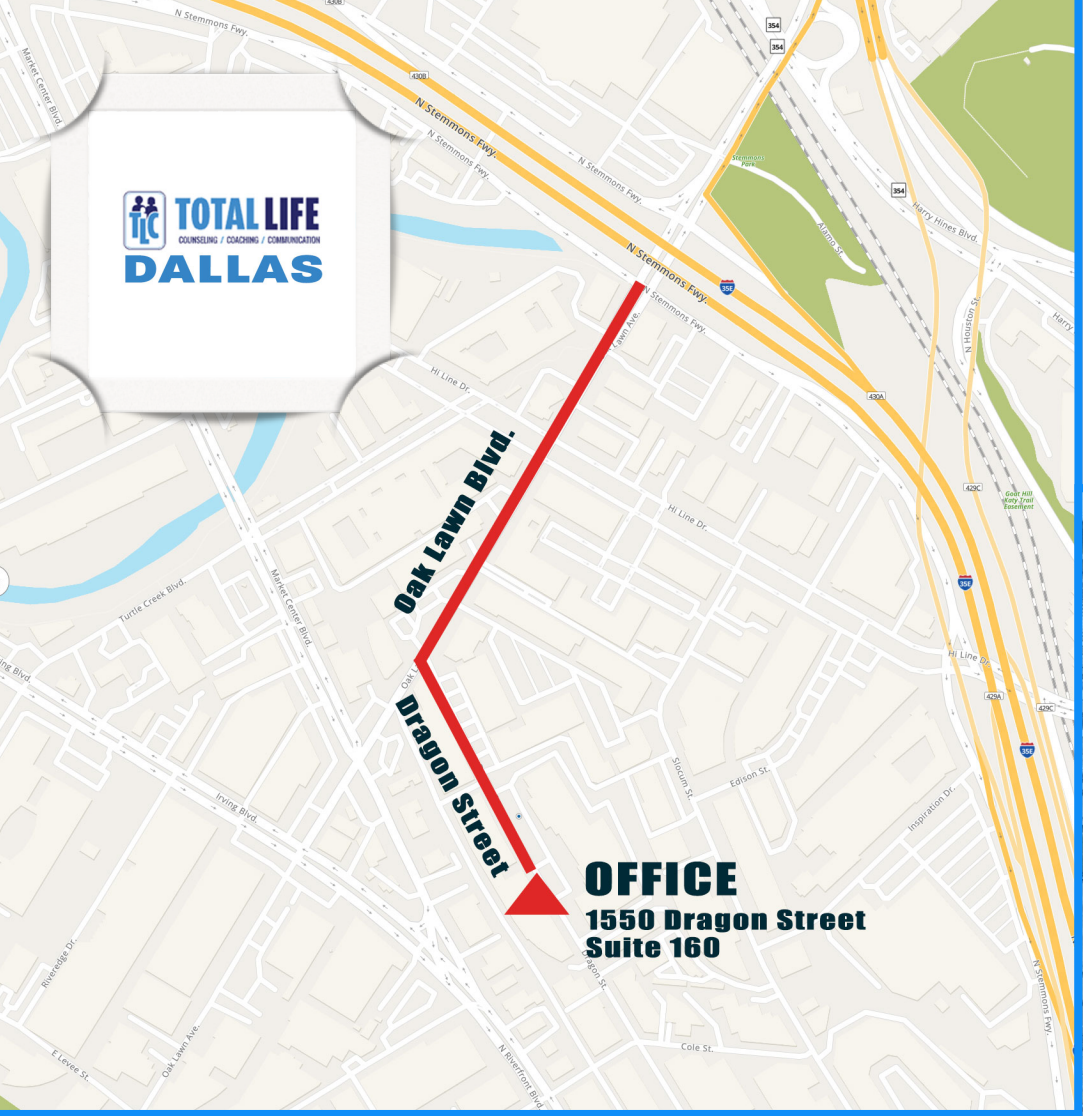
Street Address: _____

City: _____State:_____ Zip:_____

Client

Signed:_____ Date:_____

Witnessed
Signed: _____Date:_____



From Downtown Dallas: Access **Interstate 35** then exit **Oak Lawn Blvd** turning southbound. Make a left on **Dragon Street**. Our Office will be on your left. (See photo to right for visual appearance of our Building.)

TLC Dallas | Office Locator (Click link to open your GPS):

1500 Dragon Street, Suite 160, Dallas, Texas 75207

Phone: 469.757.5215

TOTAL LIFE COUNSELING

SERVING DALLAS & the LONE STAR STATE

Thank You

Total Life. Totally Committed to your mental health & wellness.

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