TOTAL LIFE COUNSELING

SERVING DALLAS & the LONE STAR STATE

WELCOME PACK

CLIENT INTAKE, INFORMATION, FORMS & RELEASES

CHILD | TEENS

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

TOTAL LIFE
COUNSELING / COACHING / COMMUNICATION
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
P: 469-757-5215
F: 407-248-0226
Dallas/Ft. Worth

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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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Patient Information Forms

Patient Name: _____ Date: _____

Parent/Guardian Information

Parent/ Guardian Name: _____ Relationship to Patient _____
Address: _____ City _____ Zip _____
Home Phone: _____ Business Phone: _____ Cell Phone: _____
Email Address: _____ Place of Employment _____
Occupation: _____
Marital Status: Single Engaged Married How Long _____? Divorced How Long _____? Widowed How Long _____?
Name of Person or Establishment who referred you _____
In case of emergency contact: _____ Relationship _____
Phone _____

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

I hereby give Total Life Counseling Center permission to provide counseling services for the patient mentioned above: Signature of parent or legal guardian:
Signature: _____ *Date:* _____

Patient's DOB: _____ Age: _____ School _____ Grade: _____

Has patient received counseling from a Pastor, Psychiatrist, or other counselor? ☐ Yes or ☐ No

If yes, Who: _____ When: _____

What was the previous chief complaint or diagnosis: _____

Has anyone in your family been treated for a mental disorder? ☐ Yes or ☐ No

If yes, Who & What were they treated for? _____

Physician's Name: _____ Date of last physical exam: _____

Significant past medical conditions and years _____

Current medical conditions (include any known allergies or dietary concerns) _____

Medications/dosage patient is currently taking and for what reason: _____

Briefly describe major reasons for coming to counseling and what you hope to accomplish: _____

Severity of Problem: ☐ Crisis ☐ Severe ☐ Moderate ☐ Mild

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

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

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Child/Adolescent
Comprehensive Psychosocial Assessment

Staff Notes
_____
_____

Family Information:

Family	Name	Age	Educ.	Occup.	At Home
Dad					
Mom					
Stepdad					
Stepmom					
Bro/Sis					
" "					
" "					
Other					

Has your child ever lived with anyone else? ☐Yes ☐No
If so, who? _____

Is your child adopted? ☐Yes ☐No

If so, how old was your child? _____

A. Your Child's Development:

Please list the approximate age at which your child:

	Age		Problems	
Walked			☐Yes	☐No
Talked			☐Yes	☐No
Toilet Trained			☐Yes	☐No
Puberty/1st Menstruation		☐N/A	☐Yes	☐No
Sexually Active		☐N/A	☐Yes	☐No

B. Family History:

Has anyone in your immediate family ever had any of the following problems?

1. Epilepsy or Diabetes? ☐Yes ☐No
2. Significant Medical Problems? ☐Yes ☐No
3. Mental Illness Requiring Hospitalization? ☐Yes ☐No
4. Counseling For Emotional Problems? ☐Yes ☐No
5. Current or past use of alcohol/drugs? ☐Yes ☐No
6. Suicidal Behavior? ☐Yes ☐No

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C. Your Child's Behavior:

1. Does your child get along well with others? ☐Yes ☐No ☐ Sometimes
2. Does your child follow instructions? ☐Yes ☐No ☐ Sometimes
3. Is your child appropriate with pets? ☐Yes ☐No ☐ Sometimes
4. Does your child have self-control? ☐Yes ☐No ☐ Sometimes
5. Has your child ever set a fire? ☐Yes ☐No ☐ Sometimes
6. Does your child cry easily? ☐Yes ☐No ☐ Sometimes
7. Has your child ever used alcohol or other drugs? ☐Yes ☐No ☐ Sometimes
8. Has your child ever experienced problems with the laws? ☐Yes ☐No
9. Has your child ever talked about, threatened or tried to harm himself or herself? ☐Yes ☐No
10. Has your child ever threatened to harmed others? ☐Yes ☐No
11. Has your child ever used tobacco products? ☐Yes ☐No

D. Your Child's Education:

1. What school is your child attending? _____
2. In what grade is your child? _____
3. Has your child attended a special education program? ☐Yes ☐No
4. Has your child repeated, skipped or had any Interruptions in his/her education? ☐Yes ☐No
5. How many days has he/she missed this year? _____

E. Activities, Interests and Strengths:

1. What does you child do in his/her spare time? _____
2. What does your child do well? _____

Staff Notes

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F. Spiritual:
Please describe your child's religious involvement if any. Are there any special religious, cultural or ethnic considerations we should be aware of as we meet with him/her?

G. Health

Has your child experienced any of the following: If Yes, When?

Soiling or lack of bowel control? ☐Yes ☐No

Urinary problems? ☐Yes ☐No

Seizures or Convulsions? ☐Yes ☐No

Eye/Ear Problems? ☐Yes ☐No

Complications from high fever? ☐Yes ☐No

Persistent Headaches? ☐Yes ☐No

Persistent Stomach Aches/Nausea Or Vomiting? ☐Yes ☐No

Sleeping Problems? ☐Yes ☐No

Physical, Sexual or Emotional Abuse? ☐Yes ☐No

Poor Appetite? ☐Yes ☐No

Significant Weight Loss or Gain? ☐Yes ☐No

Frequent Colds/Respiratory ☐Yes ☐No

Rocking, Head Banging? ☐Yes ☐No

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Coma or Unconsciousness ☐Yes ☐No _____

Serious Injury Resulting From Accidents? ☐Yes ☐No _____

Parent or Guardian's Signature **Date**

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

Issues	Descriptions	Measurable Objectives	Interventions

Diagnostic Impressions:

Axis I: _____

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15 Symptoms of Social Delays

If you can answer two or more of these symptoms about yourself or your child, this may indicate a need for help to connect socially with your peers and to prepare for the real world.

Please indicate which of these symptoms you have noticed in yourself or your child:

- ☐ Unable to recognize non-verbal cues
- ☐ Tendency to get in peers' personal space
- ☐ Annoy others to get attention
- ☐ Low self confidence
- ☐ Poor eye contact
- ☐ Only interested in myself/or them-self rather than asking an interest in peers
- ☐ Talk too much
- ☐ Lack assertion
- ☐ Impulsive or blurt out responses
- ☐ Try too hard to make friends laugh
- ☐ Inability to roll with conflict
- ☐ Have a need for justice and fairness and judges peers
- ☐ Isolate or withdraw from peers
- ☐ Always want to be first or want things my/or their way
- ☐ Friends do not call to hang out!

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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, 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 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 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.
- Administrative Services: Letters from the administrative office, insurance forms, authorization requests and/or calls to your insurance company will be billed at $15 per 15 minutes (15 minute minimum).
- 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.
- Returned checks are subject to a $42 fee.
- A cancellation fee equivalent to the cost of the session is charged for appointments by **credit/debit** only that are no show or canceled without a **2-business day** advance notice unless there is an emergency or illness.

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.

If you have any questions about our financial policy please do not hesitate to ask us. We are here to help you.

By signing below I agree to the terms listed above.

Signature_____ Date_____

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F: 407-248-0226
Dallas/Ft. Worth

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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.

Acknowledgement of Receipt: Privacy Practice Notice

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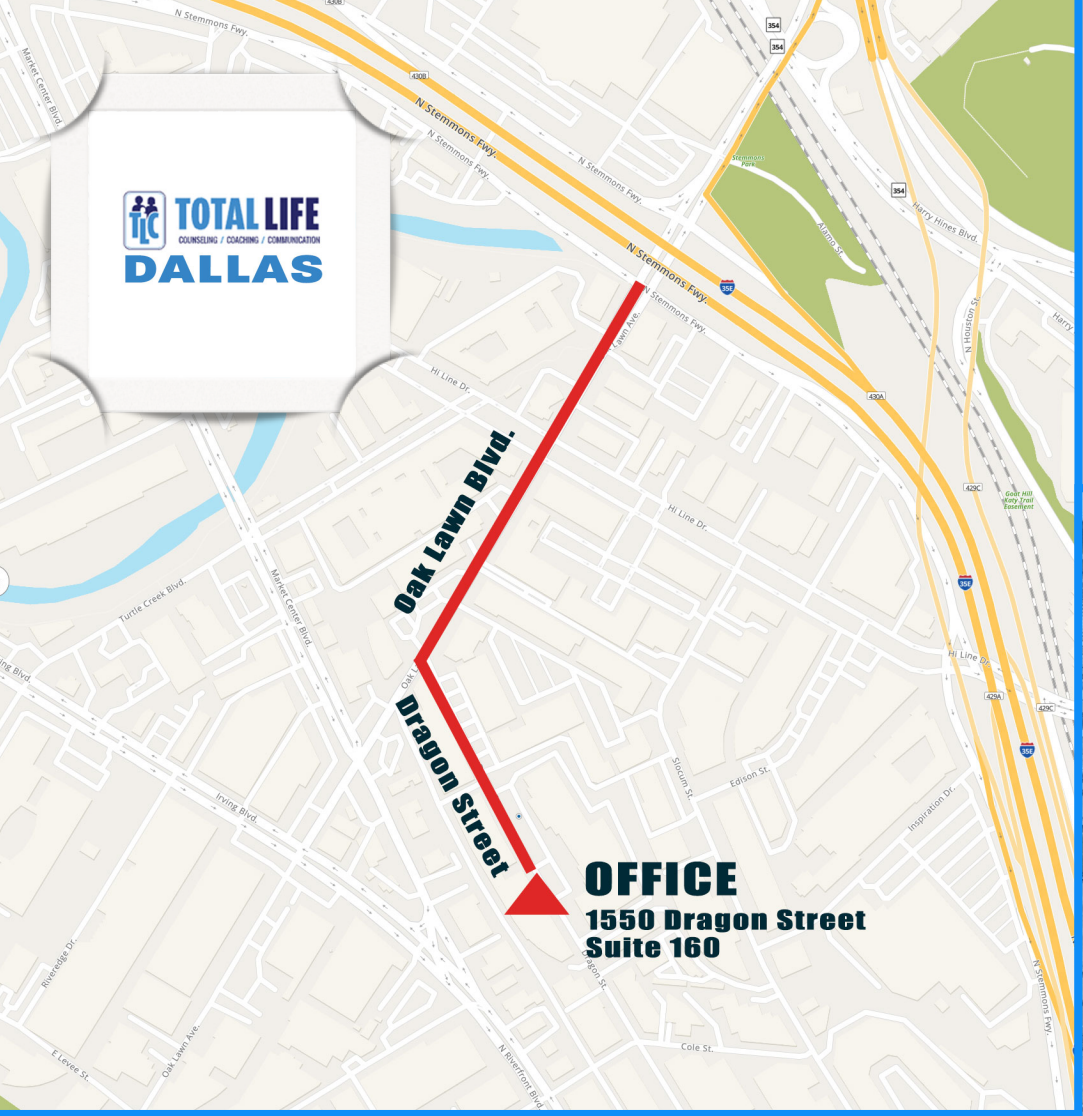
I,_____ have received a copy of Total Life Counseling Center Notice of Privacy Practices.

Street Address: _____

City: _____ State:_____ Zip:_____

Client
Signed:_____ Date:_____

Parent/Guardian
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.

Phone: 469.757.5215