Patient's Name: _____ Today's Date: _____

Birth Date:_____Age:_____Marital Status:_____;

Address:_____

City, State, Zip: _____ Referred By:_____

Employer: _____Occupation:_____

Phone 1: _____Work Phone: _____

Phone 2: _____ Email: _____

Where is it okay to leave messages? Home___; Cell____; Email____; None____

Who should be contacted in case of an emergency?

Name:_____Relationship:_____Work #:_____

Cell #: _____

Who is responsible for this account? Same as above? Yes/No

Name: _____Relationship to Patient: _____

Birth Date: _____ Address: _____

City, State, Zip: _____

Employer: _____

Occupation: _____Work #: _____ Home #:_____

ALL ABOUT YOU

About Your Education:

Where did you attend public school? _____

Did you attend college? When, where? _____

Any plans to further your education? _____ If so, when and what? _____

About Your Relationships:

Please list your marriage(s) or other important significant other relationships

	Spouse's name	Year Begun	Year Ended	Married to this person?	Children from this relationship and their ages
#1					
#2					
#3					
Please list all people who live with you					

About Your Family:

Relative	Name	Married?	Current age, or age at death	Deceased? Yes or No	Occupation
Father					
Mother					
Brother(s)					
Sister(s)					
Any other significant person?					

About Your Health:

Who is your Doctor? _____ Last Visit: _____ Concerns? _____

Do you have any chronic medical concerns? _____. If so, please list: _____

List all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had:

_____

List ***all*** medications or drugs (legal or illegal) you take or have taken in the last year.

_____

ABOUT YOUR CONCERNS

Please mark all of the items below that currently apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ☐ Abuse-emotional
- ☐ Abuse-neglect
- ☐ Abuse-physical
- ☐ Abuse-sexual
- ☐ Aggression
- ☐ Anger
- ☐ Anxiety
- ☐ Arguing
- ☐ Attention Problems
- ☐ Career concerns
- ☐ Childhood issues (your own childhood)
- ☐ Children-care
- ☐ Children-custody
- ☐ Children-management
- ☐ Choices I have made
- ☐ Codependence
- ☐ Compulsions
- ☐ Compulsive spending
- ☐ Concentration Problems
- ☐ Confusion
- ☐ Crying
- ☐ Deaths
- ☐ Debt
- ☐ Decision making
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression
- ☐ Distractibility
- ☐ Divorce
- ☐ Drug Abuse-over-the-counter medications
- ☐ Drug Abuse-prescription medications
- ☐ Drug Abuse-street drugs
- ☐ Drug Abuse-Alcohol
- ☐ Eating-poor appetite
- ☐ Eating-making myself vomit
- ☐ Eating-overeating
- ☐ Eating-under-eating
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue
- ☐ Fears
- ☐ Financial troubles
- ☐ Friendship problems
- ☐ Gambling
- ☐ Goals not being met
- ☐ Grieving
- ☐ Guilt
- ☐ Headaches, pains
- ☐ Health
- ☐ Hostility
- ☐ Impulsive spending
- ☐ Impulsiveness
- ☐ Indecision
- ☐ Inferiority feelings
- ☐ Inhibitions
- ☐ Interpersonal conflicts
- ☐ Irresponsibility
- ☐ Irritability
- ☐ Judgment problems
- ☐ Laziness
- ☐ Legal matters
- ☐ Loneliness
- ☐ Loss of control
- ☐ Losses
- ☐ Low energy
- ☐ Low frustration tolerance
- ☐ Low income
- ☐ Low mood
- ☐ Marital coldness
- ☐ Marital conflict
- ☐ Marital distance
- ☐ Marital infidelity/affairs
- ☐ Medical concerns
- ☐ Memory problems
- ☐ Menopause
- ☐ Menstrual problems
- ☐ Mixed feelings
- ☐ Mood swings
- ☐ Motivation
- ☐ Mourning
- ☐ Obsessions
- ☐ Outbursts
- ☐ Oversensitive to criticism
- ☐ Over-sensitive to rejection
- ☐ Panic or anxiety attacks
- ☐ Parenting
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Phobias
- ☐ Physical problems
- ☐ PMS
- ☐ Poor self-care
- ☐ Procrastination
- ☐ Relationship problems
- ☐ Relaxation
- ☐ Re-marriage
- ☐ Risk taking
- ☐ Sadness
- ☐ School problems
- ☐ Self Abuse-burning
- ☐ Self Abuse-cutting
- ☐ Self Abuse-other
- ☐ Self Abuse-scratching
- ☐ Self-centeredness
- ☐ Self-control
- ☐ Self-esteem
- ☐ Self-neglect
- ☐ Separation
- ☐ Sexual conflicts
- ☐ Sexual desire differences
- ☐ Sexual dysfunctions
- ☐ Sexual-(other issues)
- ☐ Shyness
- ☐ Sleep-insomnia
- ☐ Sleep-nightmares
- ☐ Sleep-too little
- ☐ Sleep-too much
- ☐ Step parenting
- ☐ Stress
- ☐ Stress management
- ☐ Suicidal thoughts
- ☐ Suspiciousness
- ☐ Temper problems
- ☐ Tension/Stress
- ☐ Thought disorganization
- ☐ Threats of violence
- ☐ Tiredness
- ☐ Tobacco use
- ☐ Violence
- ☐ Work Problems
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Employment problems
- ☐ Employment-lack of
- ☐ Employment- overdoing
- ☐ Employment-Terminations
- ☐ Other Concerns:

_____

_____

_____

_____

_____

Consent to Treat for Individuals

Please Initial Each Stating You Understand Them:

___ I have received, read and understand the Notice of Privacy Practices for this office.
___ I understand that Dr. Holmes is a Licensed Professional Counselor in the State of Texas and holds a M.Ed. and a Ph.D. in Counseling from the University of North Texas-Denton.
___ I understand that Dr. Holmes works with adults, children, and adolescents in individual, group, and family counseling.
___ I understand that as my therapist, or my child's therapist, I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.
___ I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed in that assignment.
___ I understand that if I am concerned about slow progress or lack of progress I have the right to speak to Dr. Holmes about this issue.
___ I understand that Dr. Holmes is not a medical doctor and does not prescribe medication.
___ I understand that there are some occasions when confidentiality can and/or must be breached:
1) If I direct Dr. Holmes to tell someone else in writing or verbally.
2) Dr. Holmes determines the client poses a threat to self or others.
3) Dr. Holmes is ordered by a court to disclose information.
4) Dr. Holmes suspects child, elderly, and/or handicap abuse.
5) Any sexual misconduct by a previous mental health provider will be reported.
6) Dr. Holmes may disclose your health information when required to do so by law.
___ I understand that counseling can improve, as well as, upset the equilibrium in any person and/or family.
___ I understand that if I have a complaint I can not resolve with Dr. Holmes and wish to file a formal complaint I may contact the Texas State Board of Examiners of Licensed Professional Counselors at 800-942-5540.
___ I understand that I am responsible for all fees and that payment is due at the time of service.
___ I understand there is a $35.00 return check fee and if the check is not cleared up within 30 days Dr. Jan Holmes, LPC, PLLC, will take legal action.
___ I understand that if I do not give at least 24 hours notice in canceling an appointment I will be charged $75.00.
___ I understand that the ***current*** individual counseling rate for a 45 to 50 minute session is $150.00 and that rates are subject to change with 30 days notice to current clients.

Informed Consent: By signing the treatment agreement, I acknowledge that I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that I am giving my consent to your use and disclosure on my protected health information to carry out treatment, payment activities and health care operations. I understand all the above information and agree to these conditions.

_____ _____

Client/Parent or legal guardian of Client Date Received and Read

Payment Acknowledgement

Payment is due at the time of service unless prior arrangements have been made. We accept cash, personal checks/debit cards, Visa, MasterCard, American Express and Discover Card. For clients with insurance, we will gladly accept assignment of your insurance benefits if you provide us with accurate information. However, there are times when insurance underpays or denies payment on a claim for a variety of reasons. Any remaining balance not paid by insurance within 90 days for any reason will become the responsibility of the client or the client's guardian if the client is a minor.

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Dr. Jan Holmes, LPC, PLLC insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependants. I give Dr. Jan Holmes, LPC, PLLC the right to seek services of a bill collecting agency in efforts to collect fees that my insurance company has not paid for services rendered and/or for cancelled or missed appointments.

This Release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d and 45 CFR 160-164. As a covered entity that is acting in reliance on this Release, Dr. Jan Holmes, LPC, PLLC, shall be released from liability which may result from disclosing my individually identifiable health information and other medical records.

Late Cancellation or Missed Appointments

Reserved appointment time in any office is limited and valuable. It is extremely important that all clients honor their reserved appointments. Failure to do so deprives other clients from receiving needed care in a timely fashion. So that Dr. Holmes and our other clients will not be penalized by those who fail to keep scheduled appointments, our office policy stipulates that a $75.00 cancellation fee will be charged for all sessions in which you either fail to show or cancel within 24 hours of your appointment. That charge, which is in accordance with our office's missed appointment policy for all of our clients, is to be paid prior to the scheduling of any new appointment. All clients are responsible for payment of the charge, even if an insurance client as we can not bill the insurance company when you do not show. Please feel free to discuss this and other policies with Dr. Holmes.

Your signature below indicates that you have read, understand, and agree to these policies.

X_____ _____

Signature of client or parent/guardian if client is a minor Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Health Insurance and Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the client, significant rights to understand and control how your health information is used.

We are required by applicable federal and state law to maintain the privacy of your health information. 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. This Notice takes effect September 1, 2008 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this 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 new terms of our Notice effective for all health information that we maintain, including health information we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

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 qualifications of healthcare professionals, 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 for your healthcare, but only if you agree that we may do so and sign a "HIPAA" release stating whom to release said information.

I understand and agree that if I feel I may be a danger to myself or others, I will go to the nearest emergency room or call 911 and report the problem. If at any time the counselor believes I am a danger to myself, I give permission to contact any family, friends, or professional that may be helpful in resolving the crisis. If the counselor believes I am an imminent threat to someone else, I give her permission to contact the potential victim as well as law enforcement agencies.

99 Trophy Club Drive ▪ Trophy Club, TX 76262 ▪ Phone: 817-729-7807 ▪ www.DrJanHolmes.com

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identify 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 your 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 filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Confidentiality: Your psychological records will be kept confidential and will be held in accordance with state and federal laws regarding confidentiality of such records and information. Records may be released regardless of consent under the following circumstances:

1. If you disclose information concerning physical abuse, sexual abuse, or neglect of a minor, elderly, disabled, or incompetent person, this information will be reported to the appropriate agency.
2. If you indicate you are a danger to yourself or others, confidentiality may be breached.
3. If you are in need of emergency services, appropriate emergency personnel will be contacted.
4. If a judge orders the release of your records, I must comply with the order and release the records.
5. If you report you have been sexually exploited by a mental health professional, I must report this.

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 of abuse, neglect, or domestic violence of the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of 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 institution or law enforcement official 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, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you requested copies, we have the right to charge you $0.25 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before January 1, 2005. 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.

99 Trophy Club Drive ▪ Trophy Club, TX 76262 ▪ Phone: 817-729-7807 ▪ www.DrJanHolmes.com

information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before January 1, 2005. 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.

Restriction: You have the right to request that we place additional restrictions on our use of 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).

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.

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 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 or 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 of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your treatment is conditional on your signing this agreement.

I , _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

Signature: _____ Date: _____

99 Trophy Club Drive ▪ Trophy Club, TX 76262 ▪ Phone: 817-729-7807 ▪ www.DrJanHolmes.com