Amberlea R. Shelton, MS, LPC

Welcome! Thank you for taking time to fill out this form. The information you provide is confidential, and will be helpful for you and your counselor when you meet for the first time. If you have any questions, please ask. Each person entering therapy will need to fill out his or her own paperwork even if you are entering couples therapy. Please bring this completed to your first session.

NEW CLIENT QUESTIONNAIRE

Today's Date_____

Name _____ Age _____ Date of Birth _____ /_____ /_____

Address _____
street city state zip

Home Phone: _____ _____ Yes, you may leave a message here
Cell Phone: _____ _____ Yes, you may leave a message here
Other Phone: _____ _____ Yes, you may leave a message here
Email: _____ _____ Yes, you may send me information here

Ethnicity_____ Where did you grow up? _____

Education _____ Occupation _____

Emergency contact person (name, relationship, phone, address).
_____
_____

Closest Relationships (please list name, age, relationship, and whether they live with you)

Name	Age	Relationship/Time Known	Living with you?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe your current living arrangement (Do you live with others?)
_____
_____

Have you participated in any therapy before? Y___N___ If yes, when? _____

Reason _____

What is important for Amberlea to know about that experience?

_____
_____

What brings you to therapy now?

_____
_____
_____
_____

What are your 2 most important goals for therapy?
1._____
2._____

A common list of things people seek out therapy to work on.
Please fill in: 0 - none, 1 - mild, 2 - moderate, 3 - severe.

Anxiety/Fear _____	Partnership _____	Depression _____	Self-Exploration ____
Communication _____	Alcohol/Drugs _____	Relationships _____	Being Single _____
Anger Control _____	Eating Disorder _____	Work/Career _____	Spirituality _____
Grief/Loss _____	Other Addiction _____	Divorce/Separation___	Religion _____
Sexual Issues _____	School _____	Excessive Worry ____	Aging _____
Stress Control _____	OCD _____	Mood Swings _____	Loneliness _____
Parents _____	Chronic Illness _____	Self Esteem _____	Trauma _____
Children _____	Codependency _____	Past Hurts _____	Intimacy _____
Family _____	Chronic Pain _____	Disabled _____	Emotional Health ____
Parenting _____	Bipolar Disorder ____	Phobias _____	Life Transition _____
Dissociation _____	Highly Sensitive _____	Health Concerns ____	Social Issues _____
Increased Life Satisfaction _____	Loss of Independence _____	Deeper Meaning in Life _____	Enhance Creativity _____

Do you consider yourself religious or spiritual, if so please describe?

_____

Are you currently seeing a therapist or helper? N____ Y____ If yes, please indicate their name:

_____

Have you or a family member ever been hospitalized for mental or emotional illness? Y___ N___

If yes, please explain—dates, where, reason: _____
_____

Have you or a family member or loved one ever contemplated or attempted suicide? N _____
Y _____ If yes, please explain – date(s), situation: _____

_____

Legal History (arrests, prison, DWI?)
_____

RELATIONSHIP INFORMATION

Relationship Status (check any that apply):

Single ____ Dating ____ Committed relationship ____ (how long? _____) Break Up(s) _____
Engaged ____ Married _____ (how long? _____) Separated _____ (how long? _____)
Divorced _____ (how long?_____) Other _____

Partner's Name (if applicable) _____ Age _____ Occupation _____

I would describe my friendships as: Close _____ Somewhat close _____ Distant _____
Conflicted _____ Other _____

I would describe my relationship with my mother as: Close _____ Somewhat close _____
Distant _____ Conflicted _____ Other _____

I would describe my relationship with my father as: Close _____ Somewhat close _____
Distant _____ Conflicted _____ Other _____

How many siblings do you have? _____ Names/Ages (if applicable) _____
_____
How would you describe your relationship with your siblings (if applicable)? _____
_____

CRISIS INFORMATION

Are you having any current suicidal thoughts, feelings, or actions? Y_____ N_____
If yes, explain _____
_____

Are you having any current homicidal or violent thoughts or feelings, or anger-control problems? Y____ N_____
If yes, explain _____
_____

Have you had any issues, hospitalizations, or imprisonments for suicidal or assaultive behavior? Y_____ N_____
If yes, describe _____
_____

Do you have any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Y____ N____

If yes, explain _____

_____

SUBSTANCE USE

Have you had a substance abuse or addiction history? No ____ Yes ____ (please explain):

_____

_____

Are you concerned about the behaviors listed above? Yes _____ No _____

Are others concerned about these behaviors? Yes _____ No _____

Have you ever had treatment for alcohol/substance abuse/addiction? Yes _____ No _____

Have you ever attended AA, NA, Refuge Recovery, Rational Recovery, Al-Anon, or another recovery program? Yes _____ No _____ Please describe and note if you are currently attending? _____

MEDICAL INFORMATION

Please complete to the best of your ability. If you do have a current provider, please mark "N/A" or otherwise indicate that it is not applicable. Please do not leave any spaces blank.

Psychiatric Information:

Psychiatrist's Name:

_____

Current and past psychotropic medications prescribed by Psychiatrist or MD (please note if current): _____

_____

Medical Information:

Physician's Name:

_____

Other current medications:

_____

_____

Childhood/Adolescent illnesses, hospitalizations, operations, injuries (including minor or prolonged illnesses):

_____
_____
_____

Please note if you recall experiencing or witnessing any of the following in your childhood or adult life: Animal attack, serious falls, natural disasters, sudden losses including divorce, death of family member, near drowning, severe illness or asthma, physical/emotional/sexual abuse:

_____
_____
_____

Adult illnesses, hospitalizations, operations, injuries, head injuries, etc.:

_____
_____
_____

Other Health Care Providers (Optional):

Chiropractor: _____
Acupuncturist: _____
Other healers/providers: _____

Have you been evaluated for hormonal imbalance? Y _____ N _____ If yes, most recent date: _____

Thyroid? Y _____ N _____ If yes, most recent date and results:_____

HIV Status (Optional):

Have you had an HIV test? Y _____ N _____ If yes, most recent date: _____
Test result? + _____ - _____

REFERRAL INFORMATION

Who referred you to Amberlea? _____
Please check if she may contact your referral to thank them _____

Are you aware that Amberlea does not file insurance and is considered “out-of-network”?

____ Yes ____ No

THANK YOU for taking the time to fill out this information sheet. This will be reviewed with you during your first counseling session.

This portion of the document is meant to inform you about therapy and Amberlea Shelton's policies regarding psychotherapy. These records are confidential. Please see the section on Records and Confidentiality for more information.

THERAPIST-CLIENT AGREEMENT

This agreement is meant to clarify the client-therapist relationship and any expectations of you as a client, make explicit Amberlea's ethics and the ethical guidelines of her license, and inform you of your legal rights. Amberlea R. Shelton does not discriminate on the basis of sex, gender, sexual orientation, race, ethnicity, color, national origin, age, economic status, disability, marital status, HIV/AIDS status, religion, creed, Veterans status, or political beliefs. Amberlea R. Shelton is licensed in the State of Texas as a Licensed Professional Counselor (LPC).

NATURE OF PSYCHOTHERAPY & THE THERAPEUTIC RELATIONSHIP

Amberlea's practice does not provide 24-hour or emergency therapy services. Should you or someone close to you require such service, the following referrals are offered:

- **Hotline to Help: 512-472-HELP (4357)**
- **Nearest hospital emergency room**
- **MHMR Psychiatric Emergency: 512-472-8996**
- **9-1-1 for emergency assistance**

Amberlea accepts only those clients who she believes have the capacity to resolve their problems with the assistance of psychotherapy. Although every client's goals are individualized, there are certain basic things you can expect from therapy. Essentially, therapy will help you to better manage the challenges of daily life. Discussion of your more specific goals and progress will be a constant and central part of the therapy process.

Counseling often requires the sharing of difficult thoughts and feelings and that you may feel uncomfortable at times. At other times, you may feel that you are not making enough progress. It is especially important that during these difficult times you continue to communicate with your therapist. Amberlea will want to work with you to consider all options available to help you meet your therapy goals. Although your sessions may be very emotionally and psychologically intimate, it is important for you to honor the professional nature of your relationship with your therapist. Amberlea will be unable to attend social gatherings, accept gifts, or engage in any relationship outside of the professional context of your therapy sessions. Clients are best served if the therapist-client relationship remains professional and sessions concentrate on your concerns.

RECORDS & CONFIDENTIALITY

All interactions including scheduling of appointments, your records, content of your sessions and progress in counseling, are kept confidential. In order to provide you with the best possible services, your therapist participates in case consultation with experts in her field. If she should discuss your work together in consultation it would be without identifying information with other professionals also held to the standards of confidentiality. Under certain circumstances,

your therapist may be required to share confidential information under legal mandate. These circumstances are outlined below.

All communications and records with your counselor are held in strict confidence. Information may be released, in accordance with state law, when (1) the client signs a written release indicating consent to release; (2) the client expresses serious intent to harm self or someone else; (3) there is reasonable suspicion of abuse against a minor, elderly person, or dependent adult; (4) to acquire payment for services or for billing purposes, or (5) a subpoena or court order is received directing the disclosure of information.

To protect your privacy to the greatest extent of the law, it is our policy to assert either (a) privileged communication in the event of #5 or (b) the right to consult with clients, if at all possible, before mandated disclosure in the event of #2 or #3.

•Inappropriate Behavior by Previous Therapist: If a client discloses that a previous therapist behaved in a sexually inappropriate manner, then the current therapist is legally bound to report it to the District Attorney's office as well as to the appropriate state licensing board. The client's identity need not be disclosed if he or she does not wish it.

•Sex Involving Minors: Therapists are required to report sexual activity of minors under the age of consent of 17 years of age that are not emancipated. This means sexual activity between a minor and an adult must be reported to the proper authorities for the protection of the minor. Sexual activity between a minor and another minor may be reportable, depending on the specifics of the situation.

EMERGENCY CONTACT

Please provide contact information for a person your therapist can contact in case of emergency. This contact will only be used if your therapist believes you or someone else is in immediate danger or if you become ill and unable to continue or depart therapy without assistance.

Emergency Contact Person: _____

Relationship: _____

Address: _____

Phone Number: _____

_____ (Please initial) I agree Amberlea R. Shelton may contact the above named person under the above named conditions.

CLIENT RIGHTS

If at any time or for any reason you are dissatisfied with your services, please speak with Amberlea directly. Amberlea is committed to trying to resolve your concerns. Amberlea

practices according to national and state guidelines for professional and ethical standards of care. Amberlea has a BA in Psychology with a minor in Addictive Disorders and Recovery Studies from Texas Tech University and an MS in Counseling Psychology from the University of Kansas. Amberlea is licensed in the state of Texas as a Licensed Professional Counselor (#68541). If you have reason to believe that she is practicing outside of these guidelines, you may report your concerns directly to the Texas State Board of Examiners of Professional Counselors.

Texas Department of Regulatory Agencies

The practice of licensed counselors is regulated by the Texas State Board of Examiners of Professional Counselors.

The contact information for this agency is:
Texas State Board of Examiners of Professional Counselors: Texas Department of State Health Services Mail Code 1982 P.O. Box 149347 Austin, TX 78714-9347
email: lpc@dshs.state.tx.us phone: (512) 834-6658 www.dshs.state.tx.us/counselor/

CLIENT RESPONSIBILITIES

Fees & Payment Expectations

You are responsible for paying your fee at each session. You understand that your current assessed Individual fees are $130 for 50-minutes scheduled weekly unless otherwise arranged. Individual 90- minute sessions are $180. Couples sessions are $180 for 50-minute sessions or $240 for 90-minute sessions. At a point in the future, fees may be adjusted with at least a 2-week notice before the fee change would be in effect. The agreement is to pay a $25 service charge for each check returned. After your second returned check, you will no longer be allowed to pay by check. If your debt becomes outstanding, it will be turned over to a collection agency, thereby releasing your status as a client of Amberlea Shelton.

EMAIL

In order to comply with HIPPA law I am required to inform you that my computer is password protected and my emails are secured with end-to-end encryption. *However, your therapist does not accept text or emails regarding therapy content.* If you choose to change your appointment time or schedule via emails or text please sign below to show your understanding that any email or text communications with Amberlea R. Shelton may not be considered secure. Your therapist will not be able to reply via text or email with any therapeutic response.

_____ Date _____
Client or Legal Guardian

_____ Date _____
Witness and/or Therapist

_____ (Please Initial) I understand that an email and/or text reminder may be sent with my permission to avoid a late cancellation/no-show fee for missed appointments. I agree to the terms of Amberlea's appointment reminder system.

Records Request

Therapists may have to appear in court only if subpoenaed or court-ordered by a judge. If your record is subpoenaed in a court of law, the therapist will do what she can to protect confidentiality within the limits of abiding by the law. In these cases, therapist testimony and/or case consultation will be provided at the cost of $400 per hour to be paid by the subpoenaing party at the time of court-related service. The same fee applies for all court-related proceedings, including but not limited to, meetings with attorneys and court appearances. You will be charged $400 per hour for all research, copying and administrative work requested on your behalf, including any requests for paperwork and/or clinical evaluations not including releases and insurance paperwork required for your care. Charges will be incurred for court preparation and travel as well as court appearance time. There is no sliding scale for court testimony or court case-related consultation.

Cancellations & Missed Appointments

If you are unable to attend a session due to illness or an emergency, please notify Amberlea as far in advance as possible. If you do not show up for an appointment or fail to cancel at least 24 hours prior to your appointment, you will be responsible for paying 100% of your fee for the missed session. If you are late for your appointment, you will still be charged your assessed fee. Fees for no-shows and cancellations without 24 hours notice must be paid before your next therapy meeting. Amberlea R. Shelton reserves the right to not begin or to terminate a session with clients believed to be under the influence of drugs and/or alcohol. If she believes that you are under the influence, she may end the session and may require you to find a safe method of transportation to your residence.

Termination of the Therapeutic Relationship

The majority of therapy relationships will end because the client achieves his or her goals and agrees with the therapist to terminate. However, there could be circumstances in which you or your therapist will end the relationship regardless of the other's preferences. You are free to end service at any time for any reason, whether or not your therapist feels it is advisable. Amberlea asks that you tell her if you plan to stop rather than just not returning and that you schedule one final appointment or tell her before the start of the session so that you and Amberlea can review your progress and discuss any referrals that might be beneficial to you. You will also be obligated to honor any unsettled financial obligations. PLEASE discuss all decisions regarding termination or breaks in therapy in person with your therapist to insure your file is moved or closed out appropriately and you and your therapist have some closure to your work.

There are a few situations in which your therapist may determine the need to end the therapeutic relationship. For instance, if you no longer need therapy or cannot benefit from

continuing, the therapy relationship must end. If your needs surpass your therapist's ability to help you or if the therapy relationship becomes subject to a conflict of interest, the therapist must refer you to another therapist. If you are verbally or physically violent toward the therapist or threaten or harass your therapist, the therapist reserves the right to immediately discontinue your therapy. If the therapist terminates your therapy she will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy. The therapist also reserves the right to terminate therapy if cancellations or no-shows become excessive and are unable to be dealt with in the therapeutic relationship. The therapist will discuss this with you prior to canceling services. Please be mindful of your time and mine.

CONSENT FOR THERAPY

By signing below, you are indicating that you have read and understand this informed consent statement and that any questions you have had about this document and/or the therapy process have been answered to your satisfaction. You are hereby agreeing to enter into a professional therapeutic relationship with Amberlea Shelton, MS, LPC.

Client's Signature _____ Date _____

Therapist's Signature _____ Date _____

NOTICE OF PRIVACY: HIPAA

This notice describes how your private health information may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Private Health Information may be used and disclosed in the following circumstances:

1. Information that is necessary in order to file insurance claims and successfully complete all billing and collection procedures.
2. When required for public health issues such as workman's compensation.
3. When required by any state or federal law, including cases of abuse and neglect.
4. When required for any specialized government or military functions including active personnel, reservists, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
5. When used for any clerical purposes and necessary chart audits by managed care companies.

As a client, you have rights to your Private Health Information, including:

1. The right to review your records or receive a copy of your records at any time by signing a written release. However, under certain circumstances your request can be denied. If needed, interpretation of the records will be provided.
2. The right to request information of any party that has requested information pertaining to your Private Health Information.
3. The right to receive confidential information regarding your private health information.
4. The right to revoke this consent in writing; however, this will not affect any information already disclosed.

As a practitioner, I have the responsibility to:

1. Make each client aware of the Privacy Notice:
2. At any time make the necessary changes to the Privacy Notice that are required by law.

If you as the client feel your privacy has been violated, you have the right to contact the U.S. Department of Health & Human Services Office of Civil Rights at www.hhs.gov/ocr/hipaa/.
I have reviewed and understand this notice.

Client/Parent Signature: _____ Date: _____