Erickson Counseling & Mediation PLLC

11107 McCracken Circle #A Cypress, TX 77429
EricksonCounseling.com
mde@ericksoncounseling.com
832-455-5729

Client Information Sheet

Client Name: _____

Parent if minor: _____

Address: _____

City, State: _____ Zip: _____

Phone numbers: Home: _____ Cell: _____

Email: _____

Referral source: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Employer/School: _____

Position /Grade: _____ Name of Insurance or EAP: _____

(If applicable) EAP sessions and authorization number: _____

Education Level: _____ Religion: _____

Marital/relationship status: Minor Single Married Divorced Separated Widowed

Names and ages of all children:		In your home?
_____	Age: _____	____ yes ____ no
_____	Age: _____	____ yes ____ no
_____	Age: _____	____ yes ____ no
_____	Age: _____	____ yes ____ no
_____	Age: _____	____ yes ____ no
_____	Age: _____	____ yes ____ no

Emergency Contact: _____ Phone _____

Complete HIPPA text available at www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/adminsimpregtext.pdf
Provider credentials can be verified through the Texas State Board of Examiners of Professional Counselors. Complaints can be made by calling 1-800-942-5540 or contacting: Investigations, P.O. Box 141369, Austin, Texas 78714

(Revised 8/5/22)

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Beck Anxiety Inventory (BAI)

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	☐	☐	☐	☐
Feeling hot	☐	☐	☐	☐
Wobbliness in legs	☐	☐	☐	☐
Unable to relax	☐	☐	☐	☐
Fear of worst happening	☐	☐	☐	☐
Dizzy or lightheaded	☐	☐	☐	☐
Heart pounding/racing	☐	☐	☐	☐
Unsteady	☐	☐	☐	☐
Terrified or afraid	☐	☐	☐	☐
Nervous	☐	☐	☐	☐
Feeling of choking	☐	☐	☐	☐
Hands trembling	☐	☐	☐	☐
Shaky / unsteady	☐	☐	☐	☐
Fear of losing control	☐	☐	☐	☐
Difficulty in breathing	☐	☐	☐	☐
Fear of dying	☐	☐	☐	☐
Scared	☐	☐	☐	☐
Indigestion	☐	☐	☐	☐
Faint / lightheaded	☐	☐	☐	☐
Face flushed	☐	☐	☐	☐
Hot/cold sweats	☐	☐	☐	☐

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Many times we experience thoughts that we don't recognize consciously. This questionnaire identifies possible thoughts and values that run through our mind at any given point during our life. Don't over analyze the question, just go with your gut.

Instructions:

Listed are a variety of thoughts that pop into people's heads. Please read each thought and indicate how frequently, if at all, the thought has occurred to you over the past week.

Please read each item carefully and circle the appropriate answers on the answer sheet in the following fashion:

1 = not at all

2 = sometimes

3 = moderately often

4 = often

5 = all the time

Thought	Response
1. I feel like I'm up against the world.	1 2 3 4 5
2. I'm no good.	1 2 3 4 5
3. Why can't I ever succeed?	1 2 3 4 5
4. No one understands me.	1 2 3 4 5
5. I've let people down.	1 2 3 4 5
6. I don't think I can go on.	1 2 3 4 5
7. I wish I were a better person.	1 2 3 4 5
8. I'm so weak.	1 2 3 4 5
9. My life is not going the way I want it to.	1 2 3 4 5
10. I'm so disappointed in myself.	1 2 3 4 5
11. Nothing feels good anymore.	1 2 3 4 5
12. I can't understand this anymore.	1 2 3 4 5
13. I can't get started.	1 2 3 4 5
14. What's wrong with me?	1 2 3 4 5
15. I wish I were somewhere else.	1 2 3 4 5
16. I can't get things together.	1 2 3 4 5
17. I hate myself.	1 2 3 4 5
18. I'm worthless.	1 2 3 4 5
19. I wish I could just disappear.	1 2 3 4 5
20. What's the matter with me?	1 2 3 4 5
21. I'm a loser.	1 2 3 4 5
22. My life is a mess.	1 2 3 4 5
23. I'm a failure.	1 2 3 4 5
24. I'll never make it.	1 2 3 4 5
25. I feel so helpless.	1 2 3 4 5
26. Something has to change.	1 2 3 4 5
27. There must be something wrong with me.	1 2 3 4 5
28. My future is bleak.	1 2 3 4 5
29. It's just not worth it.	1 2 3 4 5
30. I can't finish anything.	1 2 3 4 5

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Date of your most recent physical examination: _____

Please list all current medications and dosages:

Name of Medication:	Dosage:	Why do you take this?	How Long?

What lead you to schedule this appointment? Why now?

_____

_____

_____

_____

_____

What are your expectations for counseling?

_____

_____

_____

_____

_____

_____

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Have you been admitted to a psychiatric hospital? If so, where and when?

_____

_____

_____

Does anyone in your immediate or extended family have a diagnosed mental illness (Including depression and anxiety)?

_____

_____

_____

_____

When was your last use of alcohol? _____

Please describe your use of alcohol and all street/non-prescribed mood-altering chemicals:

Name of chemical:	Last use:

Have you ever utilized a substance abuse program? ie. AA, NA, inpt treatment:

_____

_____

_____

_____

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Contractual Agreement

Insurance Co-pay per Session_____ Self-Pay Rate: Initial Assessment & Session:$150, Counseling session:$150

I certify that my dependent or I have active insurance coverage with _____
Name of Insurance Company

I do hereby voluntarily agree to counseling services to be provided by Erickson Counseling & Mediation PLLC. All contracted activities and services will be performed by said provider directly through face-to-face interactions. Treatment will always involve clinically appropriate, research-based interventions. I have been made aware that the practice of counseling is an inexact science. As a result, I understand that no guarantee can be made concerning the future benefits of any treatment process or intervention that may be conducted. Furthermore, I understand that evaluations, assessments and ongoing therapy will involve the discussion of personal issues and information that may be uncomfortable or challenging at times. Feedback and dialogue is always encouraged throughout the process. Furthermore, I understand that it is my irrevocable right to change or adjust the treatment dynamics, therapeutic process, and/or frequency of sessions at any time at my sole discretion.

I understand that all scheduled appointments will be kept as scheduled. Changes requested with a 24-hour notice will be honored. E-mail and telephone contact information is made available for this purpose. A "**no-show**" is defined as occurring when the client is unavailable, either physically, emotionally, and/or volitionally, at the scheduled time to conduct services. This includes not having an adult present during child/adolescent sessions or other scheduling conflicts that impede the completion of the scheduled session. "**No-show**' sessions are not reimbursed or recuperated by providers through insurance companies. I understand that payment of the contracted rate of service is the responsibility of the client in the event that the scheduled session cannot be completed as scheduled. **The client will be charged $50 for no-shows.** A pattern of "no-shows" may terminate the therapeutic relationship.

I assign directly to Erickson Counseling & Mediation PLLC all insurance payments, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by my insurance coverage. I hereby authorize Erickson Counseling & Mediation PLLC to release all information necessary to secure the payment of services rendered. I furthermore authorize the use of my signature, insurance ID and diagnostic classification on all insurance submissions through a contracted third-party medical billing company.

All fees are set on a contractual basis between the mental health provider and the individual's particular insurance policy. Consequently, there can be no negotiation of co-pay amounts, as this is deemed unethical and unlawful by all insurance provider contracts. All self-pay rates, co-pays and fees for service are required the day of service. Prior to the beginning of the counseling relationship, I will know the agreed upon contracted rate or co-pay if applicable. If the insurance of the member or responsible party is terminated or changed in any way **it is my responsibility to inform the provider in advance** or I will be held responsible for the contracted rate of service. This is particularly important in dealing with Medicaid and Medicaid BHMO's.

Court Reports:	$150 per hour minimum one (1) hour
Court Appearance:	$150 per hour minimum three (3) hours.
Client initiated Phone Calls:	Phone calls over 15 minutes will be billed at $50 per 15 minutes.
Completion of paperwork	$25 per occurrence including corrections

_____ _____ _____
Client / Parent / Guardian (Print) Relationship Date

_____ _____
Client / Parent / Guardian (Signature) Date

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Limitations on Confidentiality

All information regarding evaluation, diagnosis, observations, interactions, and treatment of a client is confidential information that this provider will disclose only to authorized people and agencies. The client and/or parent must provide prior written permission and authorization before any information will be released to another person, agency, or professional organization either verbally or in writing. Confidentiality and privacy of all client information will be maintained to the highest standards of the law and ethical practice.

The following are legally specified and required exceptions to the laws of confidentiality:

- If a counselor learns of child or elder abuse that is currently taking place or has the probability of recurring, he or she is legally required to report that abuse to the appropriate authorities.
- If a client discloses an intention to do something that is likely to harm him/herself or others, the counselor is required to report that intention to authorities.
- If a court order/subpoena, or other legal proceeding requires disclosure all records may be released.
- If the client enters into litigation against the therapist.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations implemented standards for how information that identifies a patient can be used and disclosed. (Title 45, Code of Federal Regulations (CFR), Parts 160 and 164) The regulations apply to "covered entities" including health-care plans, health-care clearinghouses, and health-care providers. These privacy standards went into effect on April 14, 2003.

In regards to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I have been made aware of how my medical information may be used and disclosed and how I can get access to this information.

I understand confidentiality and its limitations.

_____ _____

Client / Parent / Guardian (Print) Date

_____ _____

Client / Parent / Guardian (Signature) Date

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Credit Card Authorization Form

PLEASE PRINT AND COMPLETE THIS AUTHORIZATION.
All information will remain strictly confidential.

Your credit card will be kept on file. **This is required by insurance companies and all medical practitioners.** Insurance companies require the copay at the time of service. Your credit card will be billed outside the counseling session using a secure, HIPPA compliant software. **"No-Shows" will be billed $50 based on the "No-Show" policy. Please read and understand the "No-Show" policy in the Counseling Contract**.

Client Name: _____

Cardholder Name: _____

Zip Code: _____

Credit Card Type:___Visa ___ MasterCard ___Discover ___American Express

Card Number: _____ Expiration_____

Security Code: (CVS) _____

I authorize Erickson Counseling & Mediation PLLC to charge the agreed amount to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Sign and Date Below:

Signature: _____ Date: _____

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