Life Solutions Counseling Center
www.LifeSolutionsCounselingCenter.com
Deborah (Debbie) Ferguson-Cain, PhD
Licensed Professional Counselor-Supervisor
905 West Mitchell, Arlington, Texas 76013
817-975-1449 Fax 817-375-0593

General Information
Child/Adolescent

(Note:** Due to this information's personal nature, you may leave blank uncomfortable areas**)

Child/Adolescent Name _____

Address:_____

Phone Number: (H) _____ (C) _____ Email Address _____

Parent's Preferred Method of Contact: Text_____ Email_____ Phone_____

May we send a text _____Yes _____ No or A voice message _____Yes _____ No (see page 13)

Date of Birth___/_____/_____ Age _____Sex_____

Current Grade _____School currently attending_____

Parent or Guardian Living with Child/Adolescent

Name(s)_____

Occupation_____ Place of Employment_____

Parents Marital Status: Married_____ Single_____ Divorced ____ Separated____ Living together_____

How Long?_____ How many previous marriages?_____

Siblings (include biological, adopted, foster, step, etc.)

Name	Age	Sex	Type (bio, step, etc.)	Custody ? (Y or N)

Is there any other person living in your household other than parents or siblings? □ Yes □ No

If yes, please give their names and their relationship to child/adolescent

_____

MEDICAL AND MENTAL HEALTH

Please list all medical and mental health providers for the last five years.

DOCTOR/CLINIC	COMPLETE ADDRESS	PHONE

Current medical problem(s)

_____

Do the above interfere with child/adolescent's school or social functioning? ☐Yes ☐No

If yes, explain _____

Is child/adolescent under a physician's care for physical problems? ☐Yes ☐No

Name of Primary Care Physician: _____

Telephone #_____Date of your last medical exam: _____

Current psychiatric problem(s) Is child/adolescent under the care of a psychiatrist? ☐Yes ☐No

Name of Psychiatrist _____

Telephone #_____ Date of last visit_____

Has child/adolescent been diagnosed? ☐Yes ☐No If yes, What diagnosis?_____

Does it interfere with you social/occupational functioning? ☐Yes ☐No

If yes, explain _____

Was child/adolescent ever hospitalized for a psychiatric illness? ☐Yes ☐No

If yes: Date _____ Name of Hospital and attending psychiatrist: _____

_____

PRESCRIPTION MEDICATION

Please list all medication, vitamins & supplements you are currently taking:

Medication	Amount (mg)	For what condition

PSYCHO/SOCIAL HISTORY

Abuse

Has child/adolescent ever been a victim of physical and/or sexual abuse? ☐Yes ☐ No

If yes, describe the nature of the abuse: _____

# of perpetrators _____age of onset _____ age abuse ended _____

Relationship to perpetrator_____

Please list hobbies, social/educational organizations

_____

Does child/adolescent have a best-friend? ☐Yes ☐No

FAMILY HISTORY

	1st Name	Age	History Mental Illness	Living	Drug/Alcohol Abuse	Suicide Attempt
Self (client):						
Father:						
Mother:						
Siblings:						

List other relatives with mental illness and/or substance abuse histories:

_____

List the reason(s) for seeking therapy:

_____

_____

What problem(s) or behavior(s) is child/adolescent currently experiencing ***(Circle all that apply)***

Running away	Grief & Loss	Lying	Separation/Divorce of parents
Problems at school	Friendships	Legal Problems	Depression/Anxiety
Gender Identity	Family Blending	Health/Medical Issues	Mood Swings
Panic Attacks	Sexual Behaviors	Substance Abuse	Relationship with siblings
Trauma	ADHD Symptoms	Not following rules	Self Injury
Eating Disorders	Managing Anger inappropriately		Compulsive behaviors

Others:_____

_____

_____

How have these problems affected child/adolescent's daily functioning? (***Circle all that apply).***

Change in sleep patterns	Depressed mood	Changes in Grades	Isolation
Family Interactions	Anxiety/Panic	Mood Swings	Legal
Anger Problems	Social/Friendships	Changes in appetite	Excessive worrying
Decreased concentration	School/Education	Decreased interest or pleasure	

Others, Explain._____

_____

What specific changes would you like to see during the process and outcome of our sessions?

_____

_____

Please list any other relevant information you think I should know:

_____

Insurance/EAP Information (If Applicable)

Will you be using insurance? ☐Yes ☐No (If yes, see below)

Employee Assistance Program (EAP) ☐Yes ☐No

If Yes, Which EAP?_____ Phone Number _____

Employeer_____

Have you contacted your insurance company or EAP provider to get authorization? ☐Yes ☐No

If Yes, authorization # _____

How Many sessions have been authorized? _____

Health Insurance information

If you will be using insurance, please provide the following information so that your insurance coverage may be verified prior to your appointment. You may either email a copy of the front and back of your insurance card or complete the following information and return via email at lifescc@sbcglobal.net.

Insurance Company_____

Insured (Member) Name_____

DOB of Member_____

Member ID #_____ Group #_____

Employer _____

Insurance Customer Service Phone Number: _____

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INFORMATION AND CONSENT

Thank you for selecting me as the therapist for your child or adolescent. This document informs you about my background and ensures that you understand our professional relationship.

The Texas State Board of Examiners of Professional Counselors (TSBEPC) licensed me. I have worked with children, adolescents, and adults in individual, couple, family, and group situations. I hold a doctorate from Texas A & M Commerce, in Counseling and a Master of Arts in Counseling from Dallas Baptist University. I have clinical memberships in the American Psychological Association (APA) and American Counseling Association (ACA) and a professional membership in the American Association of Marriage and Family Therapist (AAMFT).

I have practiced as a Licensed Professional Counselor-Supervisor (#63961) since 10/21/09. I define therapy, counseling, or psychotherapy, which literally means soul guiding, as a helpful, constructive dialogue between a practitioner/guide (with special training) and one or more client(s). As your guide, I hope to create a dialogue with you that will promote your specific goals and your overall health. As for you, I only accept clients in my practice who I believe have the capacity to resolve their own troubling experiences with my assistance

I will keep confidential anything you say to me, with the following exceptions: (a) you allow me to tell someone else by signing a release of information form; (b) I determine you are an imminent danger to yourself and/or others; (c) I am ordered by a judge, magistrate, and/or master of the court to disclose your information; and/or (d) you report past and/or present actions of a physically/sexually abusive nature against a minor and/or an adult who is unable to defend her/himself in a common manner (e.g., certain older, disabled, and/or otherwise physically or mentally challenged persons). Dependent upon circumstances, I reserve the right to disclose information to other family members if this disclosure seems necessary for therapy to proceed profitably. Examples of these circumstances include, but are not limited to, a minor who tells me s/he is involved in dangerous activity or an adult who tells me s/he has contracted HIV.

_____ _____ **Initials**

Other possible exceptions to confidentiality include (a) your status as a minor; (b) your parent/guardian paying for your sessions and requesting information; (c) your death; (d) my consultation with legal, mental health, and/or supervisee professionals; (e) my audio and/or video taping our sessions; and (f) when working with couples, I do not keep significant information private from either partner. As a final protection of your confidentiality, if we ever accidentally see each other in public, I will not verbally acknowledge you unless you first acknowledge me.

Treating Minor Children: Under Texas law, permission to treat minors of divorced parents must be given by the Managing Conservator, or the parent that is specifically authorized by a court order to do so. Therefore, I may ask for a copy of your current divorce decree. If pertinent, please provide a copy of a decree of guardianship or power-of-attorney.

If at any time for any reason you are dissatisfied with my services, please let me know. If we are not able to resolve your concerns, you may call the TSBEPC at (512) 834-6658 or the TSBEMFT at (512) 834-6657 and/or send written concerns to 1100 W. 49th Street, Austin, Texas, 78756-3138. Additionally, you may call the ACA at (800) 347-6647 and/or the AAMFT at (703) 838-9808. If you ever experience something you identify as a life-threatening emergency, including your unwavering commitment to kill yourself and/or someone else, please call 911.

I assure that my services will be rendered in a professional manner consistent with accepted ethical standards. Sessions are **50 minutes** in duration. Please note that it is impossible to guarantee any specific results regarding your therapy wants. Current research reveals that some people improve from therapy, some remain relatively unchanged, and some distress. However, together we will create a therapeutic experience to achieve the best possible results for you. As a way to monitor such results, I periodically will contact you after we complete our therapy experience and may ask you to participate in research.

Please keep in mind that I do not prescribe medication nor perform any medical procedures.

_____ _____ **Initials**

FEE SCHEDULE

In the return for fees of $130 per individual session, $150 per couple/family session, and $75 per group session, I agree to provide therapy services to you. If these fees should increase, I will give you at least a one-month notice to accommodate the change. Generally, I do not have a sliding scale for my fees; however, I occasionally negotiate such fees in special circumstances and upon request. The fee for each session will be due and ***must be paid*** with cash, check, or credit card at the conclusion of each session. If the fee is not paid, I reserve the right to involve a third party, who will be given the required information in order to secure the fee collection. Upon your request, I will provide a per-session or monthly receipt for all fees paid. In the event that you will not be able to keep an appointment, ***you must notify me 24 hours in advance by calling (817) 975-1449.*** If I do not receive such advance notice or you no-show, *you will be responsible for the session that you missed,* as your absence prevented me from receiving payment from other (waiting-list) clients. Any time a legal authority requires me to act on the behalf of you and/or others associated with you, I charge for such action (i.e., a fee of $400 an hour for all necessary consultation, research, driving, deposition, courtroom, etc., time). Additionally, my above session fees apply to phone conversations and e-mail exchanges occurring as a result of your initiative (i.e., your contacting me or me returning your contact) and exceeding 10 minutes.

ONLY FOR CLIENTS ACCESSING THIRD-PARTY REIMBURSEMENT
(Note: Involving a third-party reduces confidentiality.)

If you want to use your health insurance to cover my services, we often must preauthorize such coverage prior to any meeting that we have for the insurance company to reimburse me. Please note that if your health insurance company does not reimburse me despite my standardized attempts to receive payment, **you are ultimately responsible for paying me $80 (or the company's agreed-upon rate with me, whichever is higher) a session**. Some health insurance companies will reimburse clients for my therapy services and some will not. Those that do reimburse usually require you pay a co-payment before reimbursement is allowed, and then usually only a percentage of my fees are reimbursable. Because of the *reduced fee* they pay me, I allow very few insurance clients into my practice. As noted above, in the event that you will not be able to keep an appointment, ***you must notify me 24 hours in advance****.* If I do not receive such advance notice or you no-show, ***you will be responsible*** **for the appointment that you missed.**

_____ _____ **Initials**

Please keep in mind that using your health insurance to pay for my services has many disadvantages: (a) you automatically reduce your confidentiality; (b) your length of services is determined by the insurance company representative, not by you or me; (c) your quality of services, due to *in-session time used to authorize sessions and complete paperwork*, is influenced by requirements made by the insurance company from me; and (d) insurance companies require that I diagnose you and indicate that you have an "illness" from the Diagnostic and Statistical Manual of Mental Disorders (IV-TR Edition) before they will agree to reimburse me. Considering the fact that this diagnosis becomes part of your permanent insurance records and that such records can influence decisions made about potentially significant events in your life, I encourage clients to reconsider their choice of using their insurance companies to reimburse for my services. In the event a diagnosis is required, I will inform you of the diagnosis I plan to render before I submit it to the health insurance company.

If you have any questions, please feel free to ask me. By signing this, you affirm that you have read, understood, and will abide by all legally-binding stipulations contained in this document.

Print Name of Parent _____ Date _____

Parent's Signature _____

Print Name of Parent _____ Date _____

Parent's Signature _____

Name of minor _____ Date of Birth _____

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Notice of Privacy Practices

UNDERSTANDING YOUR HEALTH INFORMATION

Each time you contact Deborah Ferguson-Cain, Phd., LPC-S, Life Solutions Counseling Center, a hospital, clinic or any other "healthcare provider" information is collected about you and your mental or physical health. The information collected is called, according to the law, **Protected Health Information (PHI).** This information is maintained in files and stored in my office.

I am required by federal law to inform you of the **Health Insurance Portability Accountability Act** of 1996 **(HIPAA)** and how it relates to PHI. HIPAA requires me to keep your PHI private and to give you this notice of my legal duties and my privacy practices which is called the **Notice of Privacy Practices.** This information describes how PHI may be used and disclosed.

YOUR PHI COULD INCLUDE:

- Reasons you came for services, complaints, needs, strengths.
- Personal information including your address, phone numbers and work place.
- A treatment plan for resolving the issues that brought you to me.
- Progress notes which record the progress you are making towards a resolution.
- Information concerning current and past prescribed medications.
- History of previous interventions.
- Records I may receive from others including psychological and psychiatric evaluations, school records such as grades, attendance, ARD information and diagnostic records.

YOUR PHI COULD BE USED FOR:

- To help design a treatment plan.
- To create a strategy for problem resolution.
- To provide information to others (with or without your authorization).

USES AND DISCLOSURES OF HEALTH INFORMATION WITH AUTHORIZATION

- ***BUSINESS ASSOCIATES / REFERRAL-*** With a signed Authorization from you I may call referrals or business associates on your behalf such as psychiatrists, school counselors, and other community agencies.
- Any other uses or disclosures of your PHI not addressed in this Notice or Privacy Practices or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time.

_____ _____Initials

USES AND DISCLOSURES OF HEALTH INFORMATION WITHOUT AUTHORIZATION

When you request services from me certain uses and disclosures of your PHI are necessary and permitted by law in order to best serve you, and to process payment. The following describe the ways I may use or discloses your PHI.

- ***IMPLEMENT SERVICES/TREATMENT-*** I will use the information which I get from you or from others mainly to provide you with the best possible services, treatment and interventions.

- ***PAYMENT-*** To arrange payment for my services.
- ***HEALTH CARE OPERATIONS-*** I may use or disclose your PHI for what it is known as health care operations, some examples would be:
  - Appointment reminders – I may call or send you a letter to reschedule or remind you of appointments and services.
  - Referrals - I may refer you to other professionals or organizations for services that may be of interest to you.
  - Insurance companies may request information.
- ***OTHER CARE OPERATIONS-*** In some situations, I may use and disclose some of your PHI without your consent or authorization, below are some of those situations:
  - Texas Penal Code 261.101 requires that if I suspect, believe or have knowledge of abuse or neglect of a child/adult
    I must notify the authorities within 48 hours.
  - If I suspect, believe or have knowledge of you harming yourself or others I will notify the appropriate authorities and persons who have been threatened.
  - If I am served a subpoena or a court order I am required by law to release the requested information.
  - Federal regulations allow disclosure of substance dependency to the parents of a minor when the following conditions are met:
    - An adolescent has applied for services.
    - I believe that the adolescent, because of an extreme substance use disorder or a medical condition, does not have the capacity to decide rationally whether to consent to the notification of his/her guardians.
    - I believe the disclosure is necessary to cope with a substantial threat to the life or well-being of the adolescent or someone else.

YOUR HEALTH INFORMATION RIGHTS

Although your PHI is the property of Deborah Ferguson-Cain, PhD., LPC-S and Life Solutions Counseling Center, you have certain rights to the information and they include:

- ***Privacy Complaints-*** You have the right to file a complaint if you believe your privacy rights have been violated. All complaints must be in writing. Filing a complaint will not change the services I provide to you in any way. This complaint may be addressed to the federal Secretary of the Department of Health and Human Services, or the Texas Licensing Board of Professional Examiners. There will be no retaliation for registering a complaint.
- ***Privacy Contact-*** You can ask me to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask me to call you at home, and not at work to schedule or cancel an appointment. I will try my best to do as you request.
- You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends. While I don't have to agree to your request, if I do agree, I will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
- You have the right to look at the health information and billing records I have about you. You may request a copy of your PHI but I may charge you (please see below **LIMITATIONS TO YOUR HEALTH INFORMATION RIGHTS** for further clarification).

_____ _____Initials

- If you believe the information in your records is incorrect or missing important information, you can ask me to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to the address above. You must tell me the reasons you want to make the changes.
- You have the right to a copy of this notice.

LIMITATIONS TO YOUR HEALTH INFORMATION RIGHTS

- I reserve the right to deny PHI if access to such information is deemed by me that such disclosure of PHI would cause a threat and/or harm to you or your child.
- Per federal law 42 U.S.C. §290dd-2 as well as 42 Code of Federal Regulations (C.F.R.) Part 2, I must receive a court order or signed Authorization to Disclose or Use PHI from the adolescent before I release information relating to substance abuse or HIV about the adolescent. I must receive a court order or signed Authorization to Disclose or Use PHI from the adult before I release information relating to substance abuse or HIV about the adult. (Please refer to **OTHER CARE OPERATIONS** above for further clarification).

_____ _____Initials

SENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____ AUTHORIZE: Deborah Ferguson-Cain, PhD., LPC-S
(Parent or guardian of client)

905 West Mitchell

Arlington, Texas 76013

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY CHILD'S HEALTH RECORDS AND HEALTH CARE TREATMENT:

O Information related to the scheduling of meetings or other appointments

O Information related to billing and payment

O Completed forms, including forms that may contain sensitive, confidential information

O Information of a therapeutic or clinical nature, including discussion of personal material relevant to my child's treatment

O My child's health record, in part or in whole, or summaries of material from my child's health record

O Other information. Describe: _____

BY THE FOLLOWING NON-SECURE MEDIA:

O Unsecured email.

O SMS text message (i.e. traditional text messaging) or other type of "text message."

O Other media. Describe:

_____.

TERMINATION

O This authorization will terminate _____ days after the date listed below.

OR

O This authorization will terminate when the following event occurs:

_____.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my child's protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

_____ _____

Name of Child/Adolescent Parent of Guardian's Signature Date

Life Solutions Counseling

Cancellation Policy

When you set an appointment with a therapist, that time is reserved just for you. You are responsible for attending each session. However, I understand that, in certain circumstances, unexpected things can arise which prevent individuals from being able to keep a schedule appointment.

Therefore, I will adhere to the following policy: If I am prevented from keeping an appointment due to sickness, emergency, etc.), I will notify you as soon as possible. Similarly, if you are prevented from keeping a scheduled appointment, I ask that you notify me as soon as possible or at least **24 hours in advance**. This notice offers me time to give the appointment to another client that may be on the waiting list. If I do not receive 24 hour advance notice, you will be responsible for paying a $60 cancellation fee.

I understand the cancellation policy and agree to give 24-hour notice for any cancellations. I further give agree to pay $60 for any appointments that I miss, or that I fail to cancel according to Life Solutions Counseling policy outlined above.

_._____
Name

_____
Signature

_____
Date