Mary Lee Roberts, MS, LPC

Licensed Professional Counselor #6604
Individual and Family Psychotherapy
832-510-4790

Date:_____

Name: _____ **Occupation**: _____
Address: _____ **Company**: _____
Phone #: _____ **Business Phone**: _____
Age: _____ **DOB:** _____
Email: _____

Spouse/Significant Other/Parent Name:
_____ **Occupation**: _____
Age: _____ **DOB**: _____ **Phone**: _____

Education: ( ) High School ( ) College ( ) Graduate School

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) # of times married
Children's names and ages _____
_____
Step Children's names and ages_____
_____

Religious/Spiritual Orientation_____

FAMILY OF ORIGIN
Siblings, Age, Marital Status, Location
_____
_____
_____

Mother's name, age, health, year of death if deceased_____
_____

Father's name, age, health, year of death if deceased_____
_____
Divorced? _____ Remarried? _____

Has anyone in your family been diagnosed/treated for mental, emotional, behavioral, substance abuse disorder? Please describe: _____
_____
_____

PERSONAL

Present Health and History of medical/psychiatric conditions, hospitalizations, surgery's
Please list:

_____
_____
_____
_____
_____

Current medications and dosages:

_____
_____
_____
_____
_____

Have you been seen before for psychological issues? Please list previous therapist(s), Psychiatrist(s), hospitalization(s), and outcome of previous experience(s):

_____
_____
_____
_____
_____

Have you or are you currently abusing any substances, legal or illegal? Have you in the past? If so, please describe:

_____
_____
_____
_____

How do you take care of yourself physically? Eating (include tobacco and alcohol use), sleeping, exercise habits?

_____
_____
_____
_____
_____

OFFICE POLICIES

Please read carefully before signing

Sessions are scheduled hourly and last for approximately fifty (50) mins. Please be prompt. Your session will begin on time. If you are late, your session will end at the appointed time. To make the most of our time together, please have your check made out before the session. I do not accept credit cards. Payment (cash or check) is expected with each session. First session is cash only. Then please pay with cash or check. Returned checks will be assessed a $50 fee. Cash payment will be required after receipt of a returned check. If requested, you will be given a receipt for the session that you may file with your insurance company. My office does not file insurance. I am no longer an "in network provider" for any insurance company.

If you need to cancel your appointment, 24 hrs. advance notice is required. It is your responsibility to pay for the missed session without advance notice. Exceptions may be made for unexpected emergencies. Please text or call my phone if you have a need to reschedule or cancel an appointment. Know that I will return your calls in a timely manner. If you contact me at night or during the weekend. I will respond the following business day. Calls will he returned by cell phone. Privacy of cell phone calls and/or texts cannot be guaranteed. You will have my full attention and professional skills during our appointments. Please turn off or mute your cell phone during our session.

I am not available for phone calls/consultations outside of your appointment. I support you in having a strong support system for the daily ups and downs of life. Only a licensed M.D. has the legal right to admit a patient to the hospital. If you have a life-threatening emergency arise, please call your Psychiatrist or go to your nearest emergency room.

Strict confidentiality of all sessions will and must be maintained within the laws set by the State of Texas and the governing board of my licensure. L am required to report any serious threat of harm or abuse If I am seeing parents and children (minors) separately. I reserve the right to share information that is in the best interest of the child with the parent. I may also be subpoenaed to testify in court. Please note that I do not perform court consultations with attorneys or serve as an excerpter witness. If you are seeking therapy from someone experienced in these areas, please contact a Licensed Social Worker to better meet your needs. My fee for legal testimony, if subpoenaed by an attorney or court judge is $500 per hour, including travel and wait time. Our office facility cannot accommodate small children without adult supervision.

I have read and accept the Office Policies listed above.

_____ _____

Signature Date

If patient is a minor

I am the legal guardian and/or managing conservator and grant permission for treatment and compliance with the above office policies.

_____ _____

Signature Date

HIPAA REGULATIONS AND PATIENT RIGHTS

The following regulations specify your rights under the Health Insurance Portability and Accountability Act of 1996. Tell your mental professional if you don't understand this authorization, and they will explain it to you. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice. If it is legally required/requested that information about you leaves this office per the terms of this authorization, this office has no control as t how it will be used by the recipient. At that point your information may no longer be protected by HIPAA. If this office initiated this authorization, you must receive a copy of the signed authorization. Special instructions for completing this authorization for the use and disclosure of psychotherapy notes: HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e. paper, electronic) by a mental health professional (such as psychotherapist, psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a high standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider for an individual or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition is the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. For a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

I have read and accept the HIPPA Regulations and Patient Rights listed above.

_____ _____

Signature Date

If patient is a minor

I am the legal guardian and/or managing conservator and grant permission for treatment and compliance with the above HIPPA Regulations and Patient Rights.

_____ _____

Signature Date

MARY LEE ROBERTS, MS, LPC

Licensed Professional Counselor

RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize: To release and obtain information from:

_____ _____

_____ _____

Confidential information concerning

NAME: _____ D.O.B. _____

This release shall be limited to the following information

( ) Intake/Social ( ) Psychiatric/Medical ( ) Psychological

( ) Progress Notes ( ) Vocational ( ) Educational

( ) Drug/Alcohol Abuse/Treatment ( ) Unrestricted

( ) Diagnosis/Treatment

Release of the above information is requested for

( ) Update Psychiatric/psychological ( )Monitor Medical Status

( ) Review Prior Treatment ( )Use in Residential Placement Search

( ) Medication Verification ( ) Other -Specify _____

I understand that this consent is subject to revocation at any time, except to the extent that action has been taken in reliance on It. Any revocation of this Release must be made in writing and will automatically terminate at the time of patient termination with therapist.

NOTICE TO THE PARTY RECEIVING THIS INFORMATION

This information has been disclosed to you from records whose confidentiality is protected by state law. Where a drug and alcohol abuse client Is involved, the confidentiality of these records is also protected by Federal law. See. 42 CPR Part 2. In either event, the applicable laws, rules and regulations prohibit you from making further disclosure of these records without the specific written consent of the person to whom it pertains, or as otherwise permitted by the applicable laws, files and regulations. Please note, a general authorization for the release of medical or other information is not sufficient for these purposes.

_____ _____

Client Signature Date Parent/Guardian (If applicable) Date

If you have concerns or a complaint that need to be taken to the
Texas State Board of Examiners of Professional Counselors, you may find their contact information at: http://www.dshs.state.tx.us/counselor/ . They can also be contacted at:
Complaints Management and Investigative Section
P.O. Box 14139
Austin, Texas 78714-1369
1-800-942-1369

Your signature below indicates that you have read the intake form and agree to its terms. Your signature also acknowledges that privacy information and payment options are understood.

_____ _____
Signature Date

_____ _____
Parent/Guardian (If applicable) Date

_____ _____
Psychotherapist Signature Date

THERAPY ISSUES AND GOALS

Listed below are some of the issues and goals that I frequently deal with in therapy. Some people enter therapy with little self-awareness, while others are extremely insightful. Please take a few minutes and reflect on what you bring into this moment and the goals you wish to accomplish. This is by no means a complete list. We can add any unique needs you may have. Please **circle** the issues that apply to you at this time, Add additional ones not listed.

Depression	Bi-Polar	Anxiety
Compulsions/ Obsessions	Addiction	Anger Management
Stress Reduction	Sleep Difficulties	Eating Disorder
Body Image Distortion	ADD/ADHD	Trauma
Abuse History (sexual, physical, emotional, mental)		PTSD
Grief and Loss	Marital/Relationship Issues	Parenting Issues
Undesired Same Sex Attraction		Sexual Dysfunction/Incompatibility

Please **circle** the specific goals that you may want to accomplish in therapy. Add additional ones not listed.

Finding out who you are	Connecting with others	Controlling emotions
Expressing emotions	Focusing/concentrating	Being independent
Improving self-esteem	Asserting yourself	Overcoming fears/phobias
Increasing confidence	Discernment of others	Trusting
Codependency	Enabling	Judging
Forgiveness	Relaxation techniques	Eliminate repetitive thought patterns
Organization	Prioritizing	Authority issues
Meditation	Maintain joy, happiness, and internal peace	
Career change/Planning	Restore or improve spiritual connection	

It is recommended that you print an additional copy of the completed intake form for your personal reference. Please bring both copies with you to our first session.