Date: _____

Client Name: _____ Birthdate:

Gender: M | F | Other: _____ Relationship Status: W | M | S | D | Couple

Email: _____

Cell Phone: _____ Text OK Yes | No Message OK Yes | No

Home Phone: _____ *check or circle your respone to each question please.* Message OK Yes | No

Work Phone: _____ Message OK Yes | No

Home Address: _____

_____

Employer: _____

Position: _____

Duties: _____

Emergency Contact Name: _____

Email: _____

Cell Phone: _____ Home Ph: _____ Wk Phone: _____

Address: _____

_____

Relationship to you: _____

If Counselee is a minor: *I give permission for my child to receive counseling without a parent or guardian present.*

_____ _____ _____ _____

Printed Name Signature relationship to minor date

How did you find out about Enrichment Training & Counseling Solutions, Salley Schmid, Jennifer Alumbaugh?

Psychology Today ☐ Locals Love Us ☐ Theravive ☐ local phone book ☐ Enrichment Website ☐ internet ☐

Friend Name: _____ May I notify the referral? Yes | No *Check or circle your response*

Are you on any medications? yes | no *Check or circle your response*

Medication	dose	frequency	prescribing physician

Symptom Checklist

Please Check all that apply

☐ decrease interest in previously interesting activites	☐ highly critical of self	☐ arguing
☐ poor attendance at work / school	☐ sleep difficulties	☐ infidelity
☐ sexual difficulties	☐ roller coaster emotions	☐ headaches
☐ decrease in pleasere in previously pleasurable activities	☐ emotionally numb / blank	☐ angry
☐ communication problems	☐ weight loss/gain	☐ sad
☐ relationship disaffection	☐ scattered thinking	☐ anxious
☐ cant communicate thoughs fast enough	☐ lost sense of identity	☐ feeling alone
☐ difficulty with work / school	☐ thoughts of self harm	☐ appetite change
☐ others comment on undesirable changes observed in me	☐ thoughts of suicide	☐ low self esteem
☐ difficulty concentration	☐ low motivation	☐ can't decide
☐ thoughts of harming another	☐ high stress level	☐ obsessing

Other symptoms? _____

Prior Counseling

Therapist Name _____ Phone _____

Address _____

Therapist Name _____ Phone _____

Address: _____

Who will be responsible for paying your account? Me ☐ or Name of Payor: _____

Address: _____ Relationship to you: _____

Phone: _____ email: _____

FEES

The fee for each counseling session (approximately 50 minutes) is $100, payable at the time of each appointment unless other arrangements are made as outlined below. You may pay by cash, check, credit or debit. There is a $30 fee for all checks returned for nonpayment. If there are two instances of returned checks, all future payments must be paid with cash or by credit or debit. It is the policy of Enrichment to evaluate fees annually in January. Fees are subject to increase at this time. You will have a one month notice if your fee will be adjusted.

INSURANCE

You are ultimately responsible for your fee, your health insurance may pay a portion of the fee. It is your responsibility to file with insurance. I can provide you with receipts for paid sessions at your request.

APPOINTMENTS, CANCELLATIONS AND NO-SHOWS

At the conclusion of your initial interview you and your therapist will agree to a schedule for additional appointments. Because consistency is an important part of the counseling process, the appointment time you schedule is reserved for you and is not available to anyone else.

If you are unable to keep a scheduled appointment, you must notify your therapist a minimum of 48 hours in advance (Monday 8:00 a.m. through Friday 5:00 p.m.) Monday cancellations must be made on the preceding Thursday to avoid having to pay for the canceled or missed appointment. Insurance will not pay for missed appointments, therefore, your liability for a missed appointment or late cancellation will be the entire fee you have contracted with your therapist. If there are two instances of missed or short notice (less than 48 hours) cancellations, all future appointments must be paid for at the time of scheduling. If you arrive late, your appointment will still end at the scheduled time. .

EMERGENCIES

Enrichment Training & Counseling Solutions, P.C. does NOT provide emergency services. If you find yourself experiencing a mental health emergency please contact DePaul at 254-776-5970, or call 911 emergency services.

FINANCIAL AGREEMENT:

I understand and agree to the financial policies stated above, and to pay the contracted fee at the end of each counseling appointment. If you take a break from counseling for more than 2 months, your fee is subject to change and you may be asked to complete new intake paperwork.

SOCIAL MEDIA

While I appreciate the invitation to friend or follow you on social media, the Code of Ethics that governs my profession prohibits me from interacting with you on social media. I do have a professional face book page that offers ideas and tips for living wholeheartedly as well as words of encouragement. The QR code on the back of Enrichment business cards will link you to the Enrichment Facebook page, or you can link to if from the icon on the EnrichmentTCS.com website.

ABOUT MARRIAGE AND FAMILY THERAPISTS

A licensed marriage and family therapist (LMFT) is a mental health professional who provides professional therapeutic services to individuals and groups that involve the application of family systems theories and techniques. Services may include marriage therapy, sex therapy, family therapy, child therapy, play therapy, individual psychotherapy, divorce therapy, mediation, group therapy, chemical dependency therapy, rehabilitation therapy, diagnostic assessment, hypnotherapy, biofeedback, and related services.

A licensed marriage and family therapist holds at least a master's degree in marriage and family therapy or its equivalent, and also must complete 3,000 hours of supervised experience in the field of marriage and family therapy services.

For more information about marriage and family therapists, visit the website of the Texas State Board of Examiners of Marriage and Family Therapists at www.dshs.state.tx.us/mft or call (512) 834-6657.

Fee: $100 _____

Client Initials

If Payer is other than the myself, the client, I give my permission for appointment scheduling and attendance information to be shared with payer.

_____ Yes _____ No _____

Client Initials

Other Arrangements:_____

_____

_____

_____

Client's Signature Date

HIPAA Notice of Privacy Practices Statement

Notice of Information Practices and Privacy Statement
For Enrichment Training & Counseling Solutions, P.C.
6501 Sanger Avenue, Suite 102
Waco, Texas 76710
254-235-3500

How We Collect Information About You: Enrichment Training & Counseling Solutions, Inc. (Enrichment) and its employees and volunteers collect information through a variety of means including but not necessarily limited to Your intake information, Counseling Notes, phone call records, email records, and voice mails, that is either required by law, or necessary to process facilitate your care or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to intake documents, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about clients who request or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your request for services or to provide you with health or counseling services which may require communication between Enrichment and other health care providers, service providers, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of mental health care services you need including.

If you request or receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect data from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (www.enrichmenttcs.com) that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic data through our site. To avoid potential data capture that you visited the Enrichment website simply do not click on any of our outside affiliate links.

HIPAA is an acronym for "Health Insurance Portability and Accountability Act." HIPAA was enacted to ensure the privacy and confidential handling of medical information for all patients in the U.S. It applies to all medical and mental health service providers.

. .

I acknowledge that I have received notice, read and understand the HIPPA Practices of Enrichment Training & Counseling Solutions, Inc.

NOTICE OF COURT RELATED FEES

If you require my services for testimony or as an expert witness in court the following fees will apply:

1. $1000 per day to cover my time and the cancellation of a day's worth of clients
2. $200 dollars an hour for records and testimony preparation billed in 15 minute increments
3. Mileage reimbursement at the government sanctioned rate

Payment for billable hours as identified in points 1 and 2 must be made in full 14 days in advance of the scheduled court date.

If court is cancelled with less than 7 days' notice, the full fee of $1000 per day scheduled will still be owed and an additional fee for the same amount per day will be required for securing my time on any additional dates.

Mileage reimbursement will be billed after the court date. If additional billable hours accrue after payment is made for my time to appear in court, these hours will be billed at the same time as the mileage is billed.

I understand these fees will apply, should court participation be required.

Printed Name Signature date

Authorization for Release of Information and / or Records
Enrichment Training & Counseling Solutions, P.C.

6501 Sanger Avenue, Suite 102
Waco, Texas, 76710
254-235-3500

Permission is hereby given to ☐ - **Jaja Chen LMSW;** ☐ **Laura Abbruzzese, LPC, LCDC**; ☐ - **Salley Schmid, LMFT** to secure and/or release information for professional use, from the records of the person or persons listed below. This authorization includes the release of psychological and/or psychiatric information which may be part of the medical record. It is understood that this will include the release of drug and alcohol information. Information may be released in writing or by verbal/phone consultation.

Agencies acquiring information for other than patient treatment purposes are warned that the information is covered by Federal regulations restricting re-disclosure without further authorization by the client. This release may be revoked at any time upon notification by the signatory or client but revocation has no effect on action previously taken.

Client Name: _____ Birth Date: _____

I, the above named, hereby authorize and request: ☐ **Laura Abbruzzese, LPC, LCDC**; ☐ - **Jaja Chen, LMSW**; ☐ - **Salley Schmid, LMFT**

To disclose ☐, use ☐, and/or receive ☐ protected health information (PHI) about me to ☐ and/or from ☐ :
(*Print Name & Discipline of Individual, Agency, or Organization, mailing address, city, state, phone number, email address)*

☐ - Laura Abbruzzese, LPC, LCDC : Enrichment Training & Counseling Solutions; 6501 Sanger Avenue, Suite 102; Waco, TX 76710; 254-235-3500
☐ - Jaja Chen LMSW: Enrichment Training & Counseling Solutions; 6501 Sanger Avenue, Suite 102; Waco, TX 76710; 254-235-3500
☐ - Salley Schmid, LMFT : Enrichment Training & Counseling Solutions; 6501 Sanger Avenue, Suite 102; Waco, TX 76710; 254-235-3500

Other: _____

I understand that the disclosure/use my information will be used for the following purpose(s):

☐ To coordinate discharge planning or placement
☐ To discuss with my family the care and treatment I receive
☐ To facilitate referral / transfer of care
☐ At my request
☒ To facilitate / coordinate care
☒ For consultation

If I am signing as a parent, guardian or managing conservator of a minor or guardian of the person of an adult, I understand the information disclosed, used and/or received may contain reference to my family or me. I also authorize the disclosure, use and/or receipt of my health information regarding

☐ HIV/AIDS ☐ Alcohol and drug abuse treatment

(This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2) The federal rules prohibit you from making any further disclosure of the information without the specific written consent of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rule restricts any use of the information to criminally investigate or prosecute any client receiving chemical dependency services.)

NOTE: *Except for information related to alcohol or drug abuse treatment, the information disclosed pursuant to this authorization may not be protected by medical privacy laws and may be subject to re-disclosure by the recipient.*

You have the right to revoke this authorization at any time. To revoke this authorization, you must deliver a written statement signed by you to Enrichment Training and Counseling Solutions, P.C., which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by Enrichment, except to the extent that Enrichment has already relied upon your authorization to use or disclose your health information as describe in the Notice of Privacy Practices.
Unless this authorization is revoked earlier, it will expire on: ***at the conclusion/termination of client's services or by client's written request.***

_____

Signed (client's or legal guardian's signature) Date

If representative signing authorization, state your relationship to the individual: _____

A photo copy, facsimile or scan of this document is as valid as the original.