WHEELHOUSE COUNSELING

3303 Louisiana St., Ste. 210
Houston TX 77006
832-726-1735
www.WheelhouseCounseling.com

CONFIDENTIAL

Do not read this document unless you are a client or guardian of a client who has completed this document, or a staff member of Wheelhouse Counseling.

INTAKE PACKET

Updated 1/1/2018

People seek psychotherapy for many reasons; to heal from the past, to address the present and to prepare for the future. We are honored that you have chosen Wheelhouse Counseling to join with you in this process. Our work together will focus on your goals and values and shaping your life and relationships to support those goals and values.

Please complete the following packet in preparation for your first visit. Arriving to the initial session with this document complete will allow for more effective use of session time. This packet was tediously designed to be efficient and to not superfluously request information. Please note that all of this information will be protected in a confidential manner in compliance with HIPAA, HITECH, and Texas House Bill 300 regulations. You are encouraged to carefully read the document, as it contains essential policy and procedure information.

The information requested will help our work together. Please complete the packet to the best of your ability. If you feel uncomfortable with any portion of the form, leave it blank, and we can discuss your discomfort during our first session together.

PERSONAL INFORMATION

Name: _____
(Last) (First) (Middle Initial)
Name of Parent/Guardian (if under 18 years): _____
(Last) (First) (Middle Initial)
Birth Date: _____/_____/_____ Age: _____ Gender: □ Male □ Female □ Transgender
Vocation: _____ Number of Years in Current Job: _____
Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Preferred Phone: (_____)_____-_____ May we leave a message? □ Yes □ No
Other Phone: (_____)_____-_____ May we leave a message? □ Yes □ No
Personal E-mail: _____ May we email you? □ Yes □ No
Social Media: □ Facebook □ Twitter □ LinkedIn □ Instagram May we connect with you online? □ Yes □ No

***Please note: Electronic correspondence (e.g., text, email, e-receipt, newsletter, social media, etc.) is not considered to be a confidential medium of communication. Please speak with your therapist about protecting your private health information (PHI).

Referred By (name & relationship): _____

BILLING INFORMATION

Name on Card: _____ Card #: _____
Card Type: □ American Express □ Discover □ MasterCard □ Visa Expiration Date_____/_____ CVV#_____

Billing Address: _____
(Street and Number)
_____
(City) (State) (Zip)

***Please note: Receipts – paper or electronic – are available upon request. However, providing electronic receipts risks exposing your private health information. By requesting receipts electronically, you acknowledge the confidentiality risks in doing so.

AUTHORIZATION FOR RECURRING CREDIT CARD CHARGES

For your convenience, you may authorize recurring charges to your credit card to pay for your therapy sessions. You will be charged the week of your therapy appointment unless other arrangements have been made. The charge will be made under the name *Brandon Wheeler Therapy*. By signing in this section below, you agree that no prior notification is necessary unless the amount billed each time exceeds $500, in which case you will receive notification in advance

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify this practice in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date.

_____ _____
Client Signature (Client's Parent/Guardian if under 18) Today's Date

FAMILY INFORMATION

Emergency Contact: _____ Cell Number: (_____)_____-_____
Relationship: _____ Email: _____

Are you currently in a romantic relationship? □ Yes □ No Length of Current Relationship:____year(s)_____month(s)
Name of Spouse / Partner: _____ Gender: □ Male □ Female □ Transgender
Spouse / Partner Birth Date: _____ /_____ /_____ Age: _____
Partner Vocation: _____ Number of Years in Current Job: _____

Please List Any Children / Dependents and All Others Who Live with You

Name: _____ Age: _____ Relationship:_____
Name: _____ Age: _____ Relationship:_____
Name: _____ Age: _____ Relationship:_____
Name: _____ Age: _____ Relationship:_____
Name: _____ Age: _____ Relationship:_____
Name: _____ Age: _____ Relationship:_____

PERSONAL & FAMILY HISTORY

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ Yes □ No
If so, was your experience helpful? Why or why not? _____

Are you currently receiving any type of mental health services (psychotherapy, psychiatric services, etc.)? □ Yes □ No
Other practitioner name and telephone #: _____

Have you ever been prescribed psychiatric medication? □ Yes □ No
Please list and provide dates: _____

Have you or a member of your immediate family struggled with (current or past):

	Myself	Family		Myself	Family
Anxiety	□ Yes □ No	□ Yes □ No	Self-Discipline	□ Yes □ No	□ Yes □ No
Panic Attacks	□ Yes □ No	□ Yes □ No	Alcohol Abuse	□ Yes □ No	□ Yes □ No
Phobias	□ Yes □ No	□ Yes □ No	Drug Abuse	□ Yes □ No	□ Yes □ No
Depression	□ Yes □ No	□ Yes □ No	Gambling	□ Yes □ No	□ Yes □ No
Ongoing Sadness	□ Yes □ No	□ Yes □ No	Chronic Illness	□ Yes □ No	□ Yes □ No
Chronic Pain	□ Yes □ No	□ Yes □ No	Eating Disorder(s)	□ Yes □ No	□ Yes □ No
Self-Esteem	□ Yes □ No	□ Yes □ No	Obesity	□ Yes □ No	□ Yes □ No
Suicide Attempts	□ Yes □ No	□ Yes □ No	Anger	□ Yes □ No	□ Yes □ No
Unemployment	□ Yes □ No	□ Yes □ No	Parenting	□ Yes □ No	□ Yes □ No
School Problems	□ Yes □ No	□ Yes □ No	Communication	□ Yes □ No	□ Yes □ No
Domestic Violence	□ Yes □ No	□ Yes □ No	Forgiveness	□ Yes □ No	□ Yes □ No

	Strongly Disagree	Disagree	Neutral or N/A	Agree	Strongly Agree
I am in good physical health.	1	2	3	4	5
I am satisfied with my weekly exercise routine.	1	2	3	4	5
I am satisfied with the amount and quality of my sleep most of the time.	1	2	3	4	5
I am satisfied with my food diet (balance, quality, etc.).	1	2	3	4	5

	Strongly Disagree	Disagree	Neutral or N/A	Agree	Strongly Agree
I am able to help my children learn from my life lessons.	1	2	3	4	5
I am satisfied with my children's stated goals and desires.	1	2	3	4	5
I am comfortable providing praise for others' accomplishments, including to my children.	1	2	3	4	5
I am comfortable receiving praise for my accomplishments, including from my children.	1	2	3	4	5

	Strongly Disagree	Disagree	Neutral or N/A	Agree	Strongly Agree
I am able to spend positive time with my family and friends weekly.	1	2	3	4	5
I have a support system that encourages good life habits and helps me accomplish my goals.	1	2	3	4	5
I have someone to talk to when I am stressed.	1	2	3	4	5
When I disagree with someone important to me, we are able to find a solution together.	1	2	3	4	5

	Strongly Disagree	Disagree	Neutral or N/A	Agree	Strongly Agree
I am satisfied with my current financial condition.	1	2	3	4	5
I am able to prioritize my financial goals.	1	2	3	4	5
My partner and I share financial goals/values.	1	2	3	4	5
I am confident in my ability to change my financial habits so that I can achieve my goals.	1	2	3	4	5
I am confident that I will achieve my long-term financial goals.	1	2	3	4	5

	Strongly Disagree	Disagree	Neutral or N/A	Agree	Strongly Agree
I consider myself a spiritual and/or religious person.	1	2	3	4	5
I rely on my spirituality and/or religion for strength and support.	1	2	3	4	5
I interact with people of my shared faith at least every other week.	1	2	3	4	5
My values shape my day-to-day activities.	1	2	3	4	5

What do you consider to be your best strengths?_____

What do you consider to be your greatest personal challenges?_____

PSYCHOTHERAPY INFORMED CONSENT

This document contains important information about the services that will be provided to you as a client. Please read all the information carefully and ask any questions you may have about the content of this document. Upon signing this consent form, it will constitute an agreement between you and your therapist.

LIMITS OF CONFIDENTIALITY

All information you share in therapy will be treated with great care. It is your right that our sessions and any confidential therapy notes about you are kept private. In all but a few rare situations, your confidentiality is protected by state law, the rules of the profession, and your therapist's personal integrity. Texas state law requires us to inform you that in certain cases your confidentiality is not protected, and your information may be disclosed to the appropriate authorities/agencies. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm themselves and/or another person, the mental health professional may be required to report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the mental health professional may be required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child or vulnerable adult or has recently abused a child or vulnerable adult, or a child or vulnerable adult is in danger of abuse, the mental health professional may be required to report this information to the appropriate social service and/or legal authorities. If a client discloses that they themselves were physically or sexually abused as a child, the mental health professional may be required to report this information to the appropriate social service and/or legal authorities. This is the case even if the alleged abuser is deceased.

Prenatal Exposure to Controlled Substances

Mental health professionals may be required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

In most cases, parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes and summaries.

Legal Subpoena

Records may be subpoenaed by the court if you are involved in a legal proceeding. Please understand that your right to privacy is waived when services are ordered by the court or to be used in court. Any communication made during your counseling and treatment is not protected, and may be disclosed at trial and to the parties of the suit. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for the therapist's time even if they are called to testify by another party.

Family Secrets

When more than one individual is involved in the treatment process, a person may reveal a personal secret to their therapist without the other person(s) present. At no time will your therapist collude with some individuals against others.

(section continues to next page)

Audio / Video Recording

Neither client nor clinician is permitted to electronically record and/or broadcast any contact between client and clinician without a contract amendment signed by all parties involved and notarized validating authenticity of permission. All communication, within and outside of therapy sessions, is to remain absolutely confidential.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Today's Date

THE THERAPEUTIC RELATIONSHIP

Psychotherapy is a collaborative process between you and a therapist to work on areas of dissatisfaction and/or desired improvement in your life and assist you with life goals. For psychotherapy to be most effective, it is important that you take an active role in the process. The relationship between psychotherapist and client is the container through which change can take place. As such, the relationship is often one in which close emotional bonds develop. It is also a professional relationship in which appropriate boundaries must be maintained.

Because the therapist-client relationship is so important, you cannot be involved in an informal, social relationship or friendship that exists outside of the therapy room with your psychotherapist. Limiting this relationship to the therapy office keeps your therapeutic environment safe, secure and free of outside complications that could interfere with your therapy work. For example, your therapist will not interact with you via social media or other public forums so as to protect the therapeutic relationship.

I agree to the above understanding of the therapeutic relationship and agree to its expectations.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Today's Date

FIREARMS & WEAPONS POLICY

Counseling can include highly emotional conversations, and therefore is an inappropriate place for firearms and other weapons. No client or visitor shall carry a firearm or weapon onto any part of 3303 Louisiana St., including the parking lot, office spaces, and common areas.

I understand the above information and agree to the expectations described therein.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Today's Date

ELECTRONIC COMMUNICATION

Your therapist has taken measures to adhere to HIPAA, HITECH, and state regulations, which are designed to keep your private health information (PHI) completely confidential. However, all forms of electronic communication (e.g., text, email, e-receipt, newsletter, social media) are vulnerable to breach. Though these forms of communication can be convenient ways to interact, they are not secure. Some potential risks you might encounter if you and your therapist use electronic communication include:

- The message can be observed by unintended audiences, such as if a spouse reads your emails/texts.
- Emails and texts can be misdelivered if sent to an incorrectly typed address or phone number.
- Accounts can be hacked, giving third party access to vulnerable information.

- Email providers (e.g., Google, Yahoo, Comcast) keep a copy of each email on their servers, where it might be accessible to their employees.
- Phone apps can search for identifying information and broadcast social connections.

It is within your right to request only non-electronic communication with your therapist in order to protect your confidentiality.

Some clients are interested in sessions via video web conferencing. It is at the therapist's ongoing discretion to determine whether the condition being assessed and/or treated is appropriate for technology-assisted services.

Do you consent to receiving electronic communication from your therapist? □ Yes □ No

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Today's Date

SESSION GUIDELINES

In regards to session duration, sessions are colloquially called "one-hour sessions" but are intended to include no longer than fifty (50) face-to-face minutes, unless otherwise agreed upon prior to the date of the session. Additionally, ninety (90) minute sessions are also available to those clients who wish longer meetings. Some clients request longer sessions in order to accommodate complex family groups and other issues. Thirty (30) minute sessions are also available and can be especially useful to individuals who wish to meet with a counselor during their lunch hour. Session length must be coordinated prior to the date of the session.

In regards to session fee, standard "one-hour" sessions are offered at $130 per visit. Except in cases of life-or-death emergencies (as determined by your psychotherapist), phone call and video chat sessions cost full session fee. Sessions at 7am or earlier and 6pm or later are considered "after hours," and are accompanied by a $50 fee in addition to the standard rate. Weekend sessions are also considered "after hours."

In regards to the first contact, your psychotherapist offers 30 minutes of over-the-phone or face-to-face consultation free of charge. These free consultations are designed to help you learn how services may be able to address your concerns and/or goals. If you determine to continue sessions with your psychotherapist, you will do so at their established rate.

In regards to sliding scale fess, each therapist may agree to reduce their rate for providing psychotherapy services in particular situations though they are not required to do so. This personal matter should be discussed between you and your therapist during your initial consultation, during which a reasonable and mutually agreed upon fee should be determined.

In regards to cancellation of sessions, clients may cancel appointments through the online booking portal or by emailing info@wheelhousecounseling.com with "CANCEL APPOINTMENT" written in the subject line. **Cancellations within 48 hours of the scheduled appointment time include payment of the full session fee. If a client arrives 15 or more minutes late, the session will be canceled, and the client will be responsible for the full session fee.** Exceptions may occur in emergency situations, as determined by the clinician. If your psychotherapist must cancel an appointment due to illness or emergency, they will contact you to arrange for a new meeting date and time.

In regards to paying for sessions with your health insurance, your psychotherapist does not file your claims for you. However, your psychotherapist may be able to guide you how to be reimbursed by your health insurance Health Savings Account (HSA) or employer's Employee Assistance Program (EAP) for the session fee. Whereas your psychotherapist is not familiar with your particular health insurance plan or employee benefits, they cannot guarantee reimbursement, but will work with you to determine the best payment option.

The psychotherapy process is unique to each individual. It inevitably will include discussing personal issues to arise that may cause some discomfort. This is a normal and natural part of the relational process occurring between a client and psychotherapist. If at any point you wish to terminate your work with your psychotherapist, you are free to do so. And if you would like their recommendation for a different clinician, they will provide a referral for you (name and phone number). Your psychotherapist may make a professional decision to discontinue your therapeutic relationship with them. If this happens, you will be given advanced notification and will be offered a referral to a different clinician.

I understand the above information and agree to the expectations described therein.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Today's Date

RECORD-KEEPING PROCEDURES

Your therapist may take notes during your session. These are informal progress notes used to assist the therapist in delivering effective, efficient service to you. They are kept confidential according to HIPAA, HITECH, and state regulations. If you prefer that your therapist not take notes, please voice that request at your earliest convenience and at any point during your psychotherapy. You are entitled to receive a copy of these notes, unless your psychotherapist believes that seeing them would be emotionally damaging to you. If this is the case, they will be happy to prepare an appropriate summary instead. Whereas client notes are informal documents, they can be misinterpreted and can be upsetting. If you insist on seeing your notes, it is best to review them with your therapist so that you can discuss their content. Clients will be charged a fee for any preparation time that is required to comply with a request for notes review.

If you are under 18 years of age, please be aware that Texas law provides your parents with the right to examine your session notes. It is policy to request an agreement from parents that they consent to give up access to your notes. If you agree, your psychotherapist will provide your parents only general information on how your treatment is proceeding unless there is a high risk that you will seriously harm yourself or another person. In such instances, your psychotherapist n may be required by law to notify your parents of my concern. Parents of minors also can request to be provided with a summary of their child's sessions when they are complete. Before giving your parents any information, your psychotherapist will attempt to discuss this matter with you and will do the best he can to resolve any objections you may have about what will be discussed. The State of Texas requires that your therapist keep your notes for seven (7) years after termination of counseling/therapy services and for minors, seven (7) years after the minor turns eighteen (18). Please note that your psychotherapist does not provide treatment of minors without their parents' consent.

If the therapist's records experience a privacy breach (e.g., hacking of digital records), you are entitled to receive a notification of such an occurrence. This notice will be delivered if your PHI is viewed, used, or disclosed inappropriately.

The following uses and disclosures require a separate written authorization:

- Uses and disclosures for marketing purposes;
- Disclosures that constitute sale of PHI; and
- Any uses or disclosures no listed in this document.

If your therapist dies or is otherwise incapacitated, their clinical records will be transferred to another licensed marriage & family therapist in accordance with professional regulations. You will be provided the contact information for this documentation steward if such an event occurs.

I understand the above information and agree to the expectations described therein.

Client Signature (Client's Parent/Guardian if under 18) Today's Date

COURT APPEARNACES

In regards to the role of the therapist, our therapists cannot make recommendations about child custody or a judgement of parenting quality according to the ethical standards of the mental health profession. Fees for summary letters, disclosure of medical records, court appearances, preparations for court appearances and document submissions, and travel to-and-from court appearances are based in half-hour increments and cost $125 per thirty minutes of work.

I understand the above information and agree to the expectations described therein.

Client Signature (Client's Parent/Guardian if under 18) Today's Date

GRIEVANCES

If you feel that your therapist has violated their professional ethics code and/or state law in regards to their psychotherapy work, you can file a complaint to:

Texas State Board of Examiners for Marriage and Family Therapist (TSBEMFT)
Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369

Or you can call 1-800-942-5540 to request the appropriate form or obtain more information. This number is for complaints only.

I understand the above instructions.

Client Signature (Client's Parent/Guardian if under 18) Today's Date

WHEELHOUSE COUNSELING

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Houston TX 77006
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AUTHORIZATION TO RELEASE/OBTAIN PROFESSIONAL INFORMATION

OPTIONAL

This form fully protects your civil liberties when the following conditions are met:

1. All blanks have been filled out prior to your signing it.
2. That you understand signing this is not required as a condition for treatment.
3. That you sign it only after a specific request for information has been made.
4. That the release of information is in your best interest, and
5. That you fully understand that the release is limited to include only the agency or individual named below.

I acknowledge that this information may be used in court. I authorize the staff of Wheelhouse Counseling to release and/or obtain professional information to and/or from:

Individual / Company: _____ Phone Number: (_____)_____-_____

In Regards To: _____ Email: _____

Mailing Address: _____ _____

(Street and Number) (City) (State) (Zip)

Authorization and Signature:
I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____
Signature of Client (or Parent if Client is a Minor) Date

_____ _____
Witness Date

AUTHORIZATION TO RELEASE/OBTAIN PROFESSIONAL INFORMATION
(Page 2 of 2)

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. 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.

3. 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.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. 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 a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session 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 are 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. In order 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.

OPTIONAL

It may be helpful for your therapist to have a clearer understanding of your family. A **genogram** is structurally similar to a family tree, but serves to highlight relevant issues and relationship dynamics in addition to lineage. You can find a guide for some basics at the bottom of the page. If you are willing, please take some time to draw out family information that you think relevant to our work together.