Lindsey Eggleston Counseling, LLC
Lindsey Eggleston, MA, LPC #77613
Licensed Professional Counselor

INTAKE/

CONFIDENTIALITY

Client/Couple Name: _____

Guardian(s) of Client (if a minor): _____

Hello and welcome to the practice of Lindsey Eggleston! Therapy is a relationship between people that works, in part, because of clearly defined rights and responsibilities held by each person. This framework helps to create the safety to take risks and the support to become empowered to change. As a client of psychotherapy, or counseling, you have certain rights that are important for you to know. Your rights include:

- ✔ The right to know the level of training, credentials, and theoretical orientation of your counselor.
- ✔ You have the right to review copies of the records the counselor keeps on your behalf. However, if you do make a request to see your file, the counselor is free to tell you if he thinks it would be harmful to you or otherwise not in your best interest to see it.
- ✔ You have the right to know that the process of counseling could open levels of awareness or lead to changes that could produce pain, anxiety, or turmoil in your life or relationships.
- ✔ You have the right to decide not to receive counseling from your present counselor and/or end counseling at any time without additional obligation. If you wish, the counselor will provide you with a referral to another qualified counselor.

Please initial next to each section indicating that the information has been read.

GENERAL INFORMATION _____ (initial)
Lindsey Eggleston graduated from West Texas A&M University with a Bachelor of Arts in Psychology and a Master of Arts in Psychology. Mrs. Eggleston is a Licensed Professional Counselor #77613 in the State of Texas under the occupations code, chapter 503 which allows her to provide individual, couples, family, and group services.

There may be situations that Lindsey will refer you to another specialized therapist so you will be better served. Please note that she is not a psychiatrist (who is a medically trained doctor), and is therefore unable to prescribe medication. She is not a licensed psychologist, and is unable to administer certain diagnostic tests.

Mrs. Eggleston's approach is an empathetic talk therapy that incorporates multiple therapeutic interventions such as Rational Emotive Behavior, Cognitive/Behavioral and Solution Focused Therapy Modalities.

APPOINTMENTS _____ (initial)
Your first initial visit will be an assessment session in which concerns will be determined, and if it is decided that Mrs. Eggleston can provide your therapeutic needs, then treatment objectives will be formed together. Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate. Extended sessions are approximately 90 minutes long and are based on availability. If you must cancel or reschedule your appointment, please call

806.553.0446 or 806.350.3897 at least 24 hours in advance. Appointments that are not canceled at least 24 hours in advance will be charged the full session fee to your account.

Due to the confidentiality policy, excluding minors, we are unable to schedule, confirm, adjust, or cancel an appointment from anyone other than the client being seen unless a signed release is on file. If you and your spouse/partner are being seen together for the indicated session, it is acceptable for one party to schedule, confirm, adjust, or cancel an appointment. However, we will not notify the spouse/partner of the appointment change. In the event of a family or medical emergency a note will be made on the account without disclosing to a third party or family member unless a release is on file.

PAYMENT _____ (initial)
Therapy sessions are $145.00 per 50 minute session. Mrs. Eggleston does not accept insurance currently. Cash or Square payments are accepted.

Full payment of fees is expected at the beginning of each appointment. Subsequent sessions will then be scheduled at the conclusion of that session if determined necessary. By signing this agreement, you understand that you are fully responsible for all fees.

The fee for a declined credit card charge is $35.

Not confirming an appointment does not constitute canceling the appointment. If the client is unable to make a scheduled appointment, please contact Mrs. Eggleston or Amarillo Family Institute as soon as possible.

Missed appointments, which are not canceled or rescheduled at least 24 hours before the scheduled appointment, will be charged the <u>full amount</u>.

Two consecutive missed appointments without contacting Mrs. Eggleston will result in being taken off the schedule. If you are late for your appointment, we will end on time and not run over. Payment for appointments can be made via cash or charge. Regardless of how you intend to pay, please complete the below credit card authorization. This card will only be charged per your request for your counseling sessions or in the event an appointment is missed without appropriate cancellation or notice. Unless other arrangements are made this card will be used for all counseling fees and any charges associated with missed appointments.

Please initial your agreement to these terms:

Client #1: _____ Client #2 (partner/spouse): _____

Party Responsible for Payment Credit Card Authorization
Card Type:
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CVV (3 or 4 digits from back): _____

Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Lindsey Eggleston, MA, LPC to charge my credit card. I understand my information will be saved on file for future transactions on my account.

_____ _____

Cardholder Signature Date

LIMITS to CONFIDENTIALITY _____ (initial)

This is your therapy; the goal of which is your growth and wellbeing. There are certain legal limitations to those rights that you should be aware of. As a therapist Mrs. Eggleston has corresponding responsibilities to you. Trust and openness are essential for effective therapy. Confidentiality is carefully protected. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations:

- Suspected child abuse or neglect must be reported to the Texas Department of Family and Protective Services by law.
- Abuse, neglect, or exploitation of the elderly or disabled must be reported to the Texas Department of Family and Protective Services by law.
- Abuse of patients in mental health facilities must be reported to the State of Texas by law.
- Sexual exploitation must be reported to the State of Texas by law.
- If your records are subpoenaed or if a judge issues a court order requiring the disclosure of your records, Mrs. Eggleston is legally obligated to comply.
- If you authorize Mrs. Eggleston to release your records to another person or party, she will comply with your authorization.
- If you file a lawsuit against Mrs. Eggleston for any reason, or if you file a complaint against her with the licensing board, she may use your records and confidential information to defend herself.
- If a court order or other legal proceeding (such as a grand jury) requires the disclosure of your records or confidential information, Mrs. Eggleston will obey the court order or the grand jury subpoena.
- If Mrs. Eggleston learns of previous sexual exploitation by another mental health provider, she is required to report it to the District Attorney in the county where the alleged exploitation occurred and to the licensing board of the other professional within three (3) business days.
- Matters discussed during a family therapy session or a couple's therapy session are not confidential as to the persons present since those persons hear the statements made and participate in the discussion. However, all matters discussed during family or couple's sessions are confidential and privileged as to third parties who were not present in the session.
- Mrs. Eggleston requires a no secrets approach to counseling multiple individuals. Members of a family or a couple should not disclose information to her in a private session or outside of session that they do not want her to share with the other family members or partner. She is not the gatekeeper of your private information – you are. She will not be responsible for keeping track of what information can or cannot be shared with other participants in the family or couple therapy. If you must discuss personal information that cannot be shared, you should seek individual counseling with your own therapist.

If you have any questions regarding confidentiality, you should bring them to Mrs. Eggleston's attention so that we can discuss this matter further. Mrs. Eggleston holds confidentiality between clients in the highest regard and will make every effort to protect information shared in sessions. By signing this Informed Consent Form, you are giving consent to Lindsey Eggleston, MA, LPC to share confidential information with all persons mandated by law, with the agency that referred you and are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

USE of ELECTRONIC COMMUNICATION _____ (initial)
Mrs. Eggleston currently offers a range of Telehealth psychotherapy services via phone and secure videoconferencing within the State of Texas. *The security of e-mail and text messaging cannot be guaranteed and as such are not appropriate for discussing clinical matters*. If you need to discuss a clinical matter between sessions, please call.

Mrs. Eggleston does not allow clients to record sessions unless we have agreed to this in advance, and you have signed a specific written authorization for the taping to occur. By your signature below, you acknowledge that you understand my policy on recording sessions and you agree to abide by it.

Due to the importance of your confidentiality and the importance of minimizing dual relationships, Mrs. Eggleston does not engage in communication or relationships via social media with clients. This is to protect your privacy as well as the therapy relationship. She does not accept "friend" requests from current or former clients on any social networking site, as this can compromise clients' confidentiality and privacy.

Mrs. Eggleston would never post information about a client on a public website. She asks that you also respect your privacy and refrain from posting any "reviews" or other information regarding her practice or her on any website such as HealthGrades, Angie's List, or other forums for posting public reviews of health care providers. Posting reviews on these websites requires you to disclose your participation in therapy. Your participation in therapy is confidential and Mrs. Eggleston would rather you not risk waiving the confidentiality protections that are in place by disclosing that you have been in therapy with her on a public website. By your signature below, you agree that you will not post any "review" or any other information on any website without her prior written permission.

INTERACTIONS OUTSIDE the OFFICE _____ (initial)
If you should meet any member of the Amarillo Family Institute staff or Mrs. Eggleston in public, please know that they will not acknowledge you unless you initiate contact. It is preferred that you decide whether to disclose your acquaintance to others.

TREATMENT of MINOR CHILDREN _____ (initial)
In this practice, parents must sign an Informed Consent for counseling for any minor child. Consenting parents have the right to examine the treatment records of children under the age of 18. In order that minors may have the trust of a protected environment, it is your therapist's practice to ask the parents to forego that right. For minor clients who are older adolescents (15 years of age or older), Mrs. Eggleston will provide the parents with a summary of treatment when it is complete, and she will gladly discuss the child's progress in therapy upon request. If at any time she believes that the child is in danger, or is a danger to someone else, she will notify the parents of the concern.

It is important to note that in the state of Texas, children under the age of 17 may not have consensual sex (by law it is considered indecency with a child and therefore child abuse). Texas requires therapists breach confidentiality and report sexual activity involving children under 17 to the appropriate persons, including but not limited to parent(s)/guardian(s) and/or other responsible party(ies).

If you are a parent who is consenting to treatment for a minor child, by signing this Agreement you affirm that you are the parent of the child; that you have the legal right to consent to mental health treatment for the child; and that there has not been a Divorce Decree or any other Court Order that limits your ability to consent to the child's treatment. If the child's parents are divorced or never married, Mrs. Eggleston will require BOTH parents to consent to treatment. She will also require a copy of the Divorce Decree or any other Court Order that applies to the child before providing any services to the child, and by your signature below, you agree to provide the document immediately upon request.

COMPLAINTS _____ (initial)
You have the right to have your complaints heard and resolved in a timely manner. If we cannot work things out to your satisfaction, you may file a complaint with my licensing board, the Texas Behavioral Health Executive Council, 1801 Congress Avenue, Suite 7.300, Austin, TX 78701, Telephone: 1-800-821-3205,
or online: http://www.bhec.texas.gov/wp-content/uploads/2020/07/BHEC-Complaint-Form.pdf.
If you have a complaint concerning the HIPAA Privacy or Hitech regulations, you may contact the U.S. Department of Health and Human Services, Office for Civil Rights, at: OCRMail@hhs.gov.

DIVORCE/SEPARATED PARENTS of a MINOR CHILD _____ (initial)
If a divorce or a separation of parents involving the children of the marriage has occurred or occurs during treatment, a current copy of any relevant court documents is required to begin or continue services. If joint custody exists, the parent not bringing the child will also be contacted via letter with an intake form and an invitation to that parent to call with any questions and to participate in their child's counseling.

Mrs. Eggleston's policy is to involve both parents whenever possible. She requires a payment plan to be agreed upon by divorced or separated parents, prior to the commencement of counseling services, to provide specific terms of payment for the individual counseling sessions, and the session charges for children of the relationship, irrespective of the age of the children. This agreement will be signed by each member of the family or each party mentioned within the agreement.

Mrs. Eggleston does not provide forensic interviews, custody or visitation evaluations, or release of records for this purpose. She does not serve as an expert witness or provide testimonial services in custody suits. By signing this form, you agree not to subpoena him to court for testimony or for disclosure of treatment records regarding custody or parent fitness.

TERMINATION of COUNSELING/THERAPY _____ (initial)
Some clients need only a few counseling sessions to achieve their goals; others may require months or years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though it is requested that you participate in a termination session. You also have the right to refuse or discuss modification of any counseling techniques or suggestions that you believe might be harmful.

Mrs. Eggleston assures you that her counseling services will be rendered in a professional manner consistent with the current ethical practices promulgated by the Ethical Codes of the Texas State Boards of Examiners of Licensed Professional Counselors and the HIPAA security and privacy rules. If at any time or for any reason you are dissatisfied with services, please let Mrs. Eggleston know so that existing issues can be worked through.

Should you miss two appointments concurrently, our counseling relationship can terminate, and you will be provided with a referral list upon request to another facility, should you want to continue counseling services. You will be responsible for contacting and evaluating those referrals and/or alternatives. If you continue to not show for your appointments, (even with a 24-hour notice), you will also be referred. If you intend to discontinue counseling, please inform me as soon as possible so that other clients can be served.

RECORDS and CONFIDENTIALITY _____ (initial)
All of our communications become part of the clinical record. Your counseling records are the property of Lindsey Eggleston, MA, LPC. Adult client records must be retained for at least seven years after the file is closed. Minor client records must be retained at least five years after the client's 18th birthday or seven years, whichever is longer.

If you request a copy of your counseling records, that request must be made in writing. In her practice, Mrs. Eggleston requires that you sign a "Release of Records" form when requesting records. *Please be aware that she has determined that a reasonable and cost-based fee for providing a copy of your records is $25.00 for a file up to 50 pages and $50.00 for a file more than 50 pages*. An overall counseling summary, in lieu of records, will be provided free of charge upon request. A subpoena of records does not constitute an automatic release of records and we may seek a court order quashing the subpoena or providing protection should disclosure be deemed not in the client's best interest.

LITIGATION _____ (initial)
Please note that Mrs. Eggleston is not trained as a forensic specialist or expert witness. If you are seeking these services, she will be happy to provide you with a referral. The rights to privacy and confidentiality are paramount to the counseling relationship. She works hard to prioritize and protect these rights. Please note that testimony in court and other legal proceedings may compromise these rights. As such, Mrs. Eggleston does not voluntarily testify in court cases. If required to testify she cannot guarantee her testimony will be favorable to you and nor is she responsible for any outcome, or judgments made, regarding any court case and you agree to not hold her responsible in any way for such.

If Mrs. Eggleston is compelled to testify in court as a factual witness, her court appearance and/or testimony fee is a flat rate of $2,000 per day to herself REGARDLESS OF WHICH PARTY ISSUED THE SUBPOENA OR REQUIRES HER TO TESTIFY. These fees cover her time required for preparation, travel time (door-to-door), mileage outside Potter or Randall Counties, waiting time spent logged in for any remote hearing, and attendance at the legal proceeding, including waiting time and time spent on the stand or in deposition. *The minimum nonrefundable fee of $2,000 must be paid 5 business days in advance*.

This is required as Mrs. Eggleston will have to clear her calendar of appointments so that she may be available to appear in court. NO PERSONAL CHECKS WILL BE ACCEPTED FOR THESE SERVICES.

In the event Mrs. Eggleston receives a summons to testify less than 5 days prior to the court date, all fees due to herself will be doubled, and she reserves the right to take legal action to contest the subpoena. No further appointments will be scheduled until all court-related fees are paid in full.

Please be advised, if Mrs. Eggleston receives a subpoena to testify in a divorce and/or custody case, she will not make any custody recommendations, a recommendation on where the child should live, nor will give an opinion on parental fitness. By your signature below, you indicate your understanding of, acceptance, and agreement with this litigation policy and fee structure.

RELEASE OF INFORMATION _____ (initial)
If information needs to be released it will only be done according to state law and with a written consent (separate form) from the client indicating an informed consent of such release. In the case of marital therapy, the client is the couple, not individuals; therefore, all records can only be released when both parties consent in writing or if mandated by the court.

INCAPACITY OR DEATH _____ (initial)
In the event of the incapacitation or death of Mrs. Eggleston, it will be necessary to assign your case to another therapist and for that therapist to have possession of your treatment records. By your signature on this form, you are consenting to another LPC/ LPC-Supervisor, LMFT/LMFT-Supervisor, which are personally chosen colleagues preferred by Mrs. Eggleston, to take possession of your records OR to deliver them to another LPC/LPC-Supervisor, LMFT/LMFT-Supervisor of your choosing.

EMERGENCY SITUATIONS _____ (initial)
It is Mrs. Eggleston's desire to provide the highest level of care to clients. For scheduling and non-emergency situations, please contact her at 806.553.0446. In the event you encounter a personal emergency, which will require prompt attention, she will make every effort to accommodate an appointment. If your emergency arises after hours or on the weekend, clients are encouraged to call 911, 988, contact a family member, or go directly to the nearest emergency department.

MODIFICATION AND CONFLICT RESOLUTION _____ (initial)
It is agreed that any disputes or modification of agreement shall be negotiated directly between the therapist and client(s). If these negotiations are not satisfactory, then the therapist's client(s) agree to mediate any differences with a mutually acceptable third-party mediator, consisting first of another therapist of the practice. If these negotiations are unsatisfactory, the parties shall move to arbitration and then binding arbitration, choosing an arbitrator mutually agreeable by both. Litigation shall be considered only if and after all of these methods of resolution are given a good faith effort and are unsatisfactory.

RISKS/BENEFITS _____ (initial)
It is agreed that the client shall make a good-faith effort at personal growth and engage in the therapeutic process as an important priority at this time in his/her life. Therapy is designed to assist clients in resolving issues and dealing with painful life problems. Your therapist will make

every effort to make therapy successful in this manner; however, you should know that therapy is no guarantee that you will solve your problems and that issues will be resolved. Furthermore, please be aware that through the course of therapy, we may expose issues that may cause additional problems to you and bring more life distress. Participation in therapy means that you accept these risks and are willing to deal with the potential problems. Suspension, termination, or referral shall be discussed for lack of commitment or for any unresolved conflict or impasse between counselor and client as soon as possible.

DUTY TO WARN/DUTY TO PROTECT _____ (initial)
If my therapist believes that I (or my child, if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my therapist to contact any person who is able to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

PERSON TO BE CONTACTED	PHONE NUMBER	RELATIONSHIP

INFORMED CONSENT
ACKNOWLEDGEMENT OF RECEIPT

By signing below, I give my informed consent for Lindsey Eggleston, MA, LPC to provide counseling services and psychotherapy to myself and/or my child as set forth below.

I have read (or had read to me) this Agreement, I understand the terms of this Agreement, and I agree to comply with them. I understand that this Agreement is a contract between me and Lindsey Eggleston, MA, LPC and may be legally enforced as a written contract. I agree that this Agreement will stay in effect until I revoke it in writing. I understand that any revocation of this Agreement must be dated after the date of this Agreement and must be provided to Mrs. Eggleston. I further agree that a copy of this Agreement has the same force and effect as the original.

Client Printed Name: _____

Client Signature: _____ Date: ___ / ___ / ___

APPLICABLE for MARRIAGE/COUPLE

Client Printed Name: _____

Client Signature: _____ Date: ___ / ___ / ___

APPLICABLE for MINOR

Client Printed Name: _____

Parent/Guardian Signature: _____ Date: ___ / ___ / ___

Parent/Guardian Signature: _____ Date: ___ / ___ / ___

Signature of Therapist: _____ Date: ___ / ___ / ___

HIPAA / HITECH
ACKNOWLEDGEMENT OF RECEIPT

Printed Client's Name: _____

Client's Birth Date: ____/____/____

The Office of Lindsey Eggleston, MA, LPC, is required by law to maintain the privacy of and provide individuals with the "Notice of Privacy Practices" with respect to your PHI/ePHI (Protected Health Information/ Electronic Protected Health Information). This notice is located on our website and in paper format with our informed consent. You may also receive a paper copy at no charge upon your request. If you have any objections to this notice, please ask to speak with or leave a message at 806.374.5950 for my HIPAA/ HITECH Certified Office Administrator.

I hereby acknowledge that I received and reviewed the HIPAA/HITECH Notice of Privacy Practice Document.

By signing below you acknowledge you have read this notice and agree to the terms.

Client Printed Name: _____

Client Signature: _____ Date: ___ / ___ / ___

APPLICABLE for MARRIAGE/COUPLE

Client Printed Name: _____

Client Signature: _____ Date: ___ / ___ / ___

APPLICABLE for MINOR

Client Printed Name: _____

Parent/Guardian Signature: _____ Date: ___ / ___ / ___

Signature of Therapist: _____ Date: ___ / ___ / ___

INTAKE FORM
PERSONAL INFORMATION

CLIENT(S) NAME: _____

LEGAL GUARDIAN(S) (if client is a minor): _____

ADDRESS: _____

PRIMARY PHONE: (_____) _____

DO YOU AUTHORIZE TEXTS to this NUMBER (circle one): YES NO

PRIMARY EMAIL: _____

Birthdate: _____

Birth State: _____

Age: _____

Race/Ethnicity: _____

Relationship Status: _____

Year/degree of school: _____

Occupation/school: _____

Employer: _____

SPOUSAL INFORMATION (skip if not relevant to therapy)
Spouse's name: _____

Spouse's Birthdate: _____

Wedding date: _____

Either been divorced? _____

If so, who? _____

How long was the previous marriage?: _____

Children with previous spouse?: _____

Spouse's employer: _____

Spouse's occupation: _____

GENERAL INFORMATION
Names of persons with whom the client is now living with and their relationship to the client:

NAME	AGE	RELATIONSHIP to CLIENT

Emergency Contact: _____

Phone: _____

Address: _____

Relationship to the client: _____

State in a short phrase or sentence current reasons for seeking therapy (presenting issue):

When did the present problem start?

Circle the severity of the concern in regards to the presenting issue:

MILDLY UPSETTING	MODERATELY SEVERE	VERY SEVERE	EXTREMELY SEVERE	COMPLETELY INCAPACITATING

Therapy/counseling before? YES or NO
If yes, how many sessions? _____

Are you currently seeing another therapist/counselor? YES or NO

Circle the type of therapy/counseling received:

CLINICAL PSYCHOTHERAPY	PASTORAL COUNSELING	ENRICHMENT THERAPY	OTHER

How satisfactory was the therapy/counseling received (1 being not satisfied to 5 being satisfied)?

1	2	3	4	5

What else, if anything, has been attempted to correct the problem?

Describe your (client) relationship with your father or father's relationship with adolescent (if parent).

Describe your (client) relationship with your mother or mother's relationship with adolescent (if parent).

In your estimation, circle how interested in counseling you are now:

SOMEWHAT	MODERATELY	VERY INTERESTED

Any other information important in preparation for counseling:

What is the anticipated outcome of therapy? What is/are your goal(s)?

Are you currently taking medication? ____ Yes ____ No If yes, please list names, dosages, and prescribing doctor for each.

INTAKE INFORMATION
ACKNOWLEDGEMENT OF RECEIPT

By signing below you acknowledge you have read this notice and agree to the terms.

Client Printed Name: _____

Client Signature: _____ Date: ___ / ___ / ___

APPLICABLE for MARRIAGE/COUPLE

Client Printed Name: _____

Client Signature: _____ Date: ___ / ___ / ___

APPLICABLE for MINOR

Client Printed Name: _____

Parent/Guardian Signature: _____ Date: ___ / ___ / ___

Signature of Therapist: _____ Date: ___ / ___ / ___