Client Intake

Jessica Romero, M.A., LPC
Jessica Romero Counseling LLC
Amarillo Family Institute

Client Full Name:____ Birthdate __________

Legal Guardian/Parent #1 (if client is a minor):____

Legal Guardian/Parent #2 (if client is a minor):____

Primary Address:____
Street Address City State Zip

Primary Phone:____

Cell Phone:_______________________________ Permission to leave a message? YES NO

Email Address:____

Permission to email and/or text? YES NO

Employer/School:____

Occupation/Grade/Major:____

Name of persons with whom you are now living and their relationship to you (include ages):

Name	Relation to Client	Age

Emergency Contact: ____________________________________

Phone: ____________________________________

Address: ____________________________________

Relationship to the client: ____________________________________

PARTY RESPONSIBLE FOR PAYMENT (If different from Client)
This does not permit them access to the records unless the client is a minor and the responsible party is legal guardians/parents. You may be asked to sign a release of information form so that your counselor may discuss fees and payments with this party.

Name ____________________________ Date of Birth _________________________

Address ____
Street Address City State Zip

INTAKE AND HISTORY
State the reasons for seeking therapy (presenting issue and symptoms):

____

____

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

Mildly Unsetting	Moderately Severe	Very Severe	Extremely Severe	Completely Incapacitating

When did the problem start? ____

Any major triggers or events preceding the symptoms?

____

Any history of head injuries/trauma (including concussions)? YES or NO

If so, what and when? ____

How frequent do the symptoms occur?

Hardly ever	Occasionally	Half the time	Most days	Every day

Previous Counseling/Therapy before? YES NO

If yes, how many sessions? ____________________________ When?___________________________

With whom? ____

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

1	2	3	4	5

Present physical health:____

____

Any religious affiliations: ____

Current level of personal importance: None Some Very

STATED GOALS OF THERAPY
(If parental goals differ from client goals, please provide both)

What is the anticipated outcome of therapy? ____

____

What is/are your goal(s)? ____

____

What is your expectation for how long it will take you to reach these goals?

____

Are you currently taking medication? YES NO If yes, please list names, dosages, and prescribing doctor for each.

____

____

Treatment Plan [to be determined by Therapist and Client (and parents/guardians, if client is a minor) together]:

____

____

Client Informed Consent

Jessica Romero, M.A., LPC
Jessica Romero Counseling LLC
Amarillo Family Institute

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

GENERAL INFORMATION _____ (initial)
I am an LPC, #84800 (Licensed Professional Counselor) having met the requirements of the State of Texas under the occupations code, chapter 503 that allows me to provide individual, couples, family, and group services. I have graduated with my Master of Arts in Professional Counseling from West Texas A&M University. I have earned my LPC license by completing the 3000 hours required under supervision. I am trained in Level 1 Restoration Therapy. My approach is an empathetic talk therapy approach that incorporates multiple therapeutic interventions such as Family Systems, Cognitive/Behavioral, Solution Focused, Attachment-Based, Synergetic Play Therapy, and Restoration Therapy Models. Additionally, I will seek to incorporate the faith of the clients along with aspects of a spiritual formation such as prayer, bible study, worship, service, small groups, etc. into the therapeutic interventions, if you so desire. I work with individuals (with specialization in children, adolescents, and young adults) and families dealing with various issues in their lives. I also work with parents in the development of parenting skills related to Attachment-Based Parenting. Although I am capable of handling a variety of problems, there may be situations in which I will recommend you to another specialized therapist so that you will be better served. Please note that I am not a psychiatrist, (who is a medically trained doctor), so I am unable to prescribe medication. Also, I am not a Licensed Psychologist, and I am unable to administer certain diagnostic or evaluative tests.

APPOINTMENTS _____ (initial)
Your first initial visit will be an assessment session in which you and I will determine your concerns, and if we both decide that I can provide for your therapeutic needs, then we will work on treatment objectives together. Appointments are typically scheduled weekly based on availability and run for approximately 45-50 minutes, with an exception for children under the age of 12 whose appointments typically last 40-45 minutes. More frequent sessions are available if determined appropriate. Group/extended sessions are approximately 90 minutes long and will be charged the total of one session fee plus half a session fee. If you must cancel or reschedule your appointment, please call 806-553-0534 at least 24 hours in advance. Appointments that are not canceled at least 24 hours in advance will be charged half the session fee to your account. Appointments that are not cancelled and the client does not show for it – referred to as a "no show" - are charged the full session fee to your account. Not confirming an appointment does not constitute canceling the appointment. If you are late for your appointment, we will end on time and not run over.

Due to our 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/ex-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/ex-partner of the appointment change. In the event of a family or medical emergency, a note will be made on the account without disclosing information to a third party or family member unless a release is on file.

FEE SCHEDULE _____ (initial)
Licensed Counseling Sessions for an individual are **$130** a session. Full payment of fees is expected at the beginning of each appointment. Subsequent sessions will then be scheduled after that session if determined necessary. I do not accept insurance at this time, but I can offer a Superbill or Flex Spending Sheet for you to give to your insurance company. Whether or not the Superbill or Flex Spending Sheet is accepted is between you and the insurance company. Payments can be made in cash, check, or by charge through Square credit/debit card payments. **Please make checks payable to Jessica Romero Counseling, LLC.** If co-parents decide to split the sessions fees for the minor client or for parenting sessions, any negotiations in the payment arrangements will be settled between the co-parents to ensure that the full fee of $130 is met every session. If any changes are made to the arrangements for payment, the responsible parties will communicate those changes to Jessica. By signing this agreement, you understand that you are fully responsible for all fees.

CONFIDENTIALITY OF ALL ELECTRONIC COMMUNICATIONS _____ (initial)
This includes but is not limited to the following: Email, Zoom (or any other face time service), chat, texting, mobile devices, cell phones, or fax. Please know that our office will maintain your confidentiality to the best of our ability; however, we cannot guarantee this with any electronic communication. If you choose to email me, please limit the contents to pragmatic and/or clinical concerns. In the event you are contacted or place a call to our staff, please be aware that unless we are both on landline phones, the conversation is not considered confidential, and it is possible that your PHI/ePHI could be exposed. Likewise, text messages are not confidential, and it is not advised or appropriate to converse about personal issues via text. Face-to-face sessions serve this purpose. I will make every effort to keep all information confidential. Likewise, it is important that you carefully determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors, and friends. Please only communicate through a computer that you know is safe wherein confidentiality can be ensured. Be sure to fully exit all online counseling sessions and emails. By signing this agreement, you understand that if you communicate through your tablet or phone, you release the therapist from any breach of confidentiality when signing this document. If you are unable to connect or are disconnected during a session due to a technological breakdown, please try to reconnect within 10 minutes. If reconnection is not possible, call 806-553-0534 to schedule a new session time.

CONTACT OUTSIDE OF SESSIONS _____ (initials)
You may contact me outside of session times via email, call, or text. I will not respond to emails, texts, or answer calls on the weekends or after work hours. Please limit contact outside of the session to scheduling issues. Please know that any phone call that lasts for more than **15 minutes** will accrue session fees based on the length of phone call. Phone calls that last 15-29 minutes result in a half-session fee. Phone calls that last 30 to 60 minutes result in a full session fee. Additionally, emails and texts sent by clients and/or their guardians pertaining to clinical information and concerns regarding the client and requiring a therapeutic response is considered a **consultation**: therapeutic consultation will not be provided via email or text by the therapist. Instead, the therapist will only respond to set up an appointment (i.e. client/parent session via phone or in office) to address the concerns and/or questions.
Email: jromerocounseling@gmail.com
Phone: (806) 553-0534 (accepts calls and texts)
Work Hours: Monday-Thursday 9AM – 5PM.
Calls, Emails, and Texts sent during non-working hours will be returned within the following two business days (returned by Tuesday if left on Friday-Sunday).

LITIGATION _____ (initial)
In unusual cases, you may become involved in litigation that may require my participation. Please note that I am not trained as a forensic specialist or expert witness. If you are seeking these services, I would be happy to provide you with a referral. The rights to privacy and confidentiality are paramount to the

counseling relationship. I work hard to prioritize and protect these rights. Please note that testimony in court and other legal proceedings may compromise these rights. As such, I do not voluntarily testify in court cases. If required to testify I, Jessica Romero, am not responsible for any outcome, or judgments made, regarding any court case and you agree to not hold me responsible in any way for such. If I am compelled to testify in court as a factual witness my court appearance and/or testimony fee is a flat rate of $2,000 per day, with a minimum charge of $2,000. The minimum nonrefundable fee of $2,000 must be paid 5 business days in advance as per Texas law. This is required as I will have to clear my calendar of appointments and prior engagements so that I may be available to appear in court. If your court date is postponed or canceled and I must again clear my calendar to attend court, you will be responsible for an additional full fee. In the event I am required to be available for testimony beyond the first court day, each day will be charged at the $2,000 flat-rate fee. I require a minimum of 5 days advanced notice before the court appearance to adequately prepare. In the event I receive a summons to testify with less than 5 calendar days' notice, all fees due will be doubled. You will receive an additional invoice for meal expenses. You will receive an invoice for any travel outside of Potter or Randall counties.

No further appointments will be scheduled until all court-related fees are paid in full. If all fees are not paid within one calendar month they may be brought to collections.

Please be advised, if I, Jessica Romero, receive a subpoena to testify in a divorce and/or custody case, I will not make any custody recommendations, a recommendation on where the child should live, nor will I give an opinion on parental fitness.

By your initials, you acknowledge you have read this notice and agree to the terms, and are fully responsible for all fees.

CLIENT RECORDS _____ (initial)
All our communications become part of the clinical record, including electronic communication. Adult client records are disposed of seven years after the file is closed. Guardians or conservators do have access to child-client files and will need to sign for the consent of services (within joint custody cases, only one guardian or conservator is needed to sign for consent for the child). Minor client records are disposed of seven years after the client's 18th birthday. Should you request a copy of your counseling records, please be aware that a $30.00 record preparation fee will be incurred for files under 50 pages, a $50.00 record preparation fee will be incurred for files 50-100 pages, 50 cents a page for every page above 100 pages, and any shipping and mailing fees. Additionally, a **"Release of Records"** form must be signed. Once a **written** request is made, I have 15 consecutive days to provide you with your records.

RELEASE OF INFORMATION _____ (initial)
If information needs to be released it will only be done according to state law and with written consent (separate form) from the client indicating 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 my incapacitation or death, 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 myself, to take possession of your records OR to deliver them to another LPC/LPC-Supervisor, LMFT/LMFT-Supervisor of your choosing.

DUAL RELATIONSHIPS & SOCIAL NETWORKING _____ (initial)
Not all dual relationships are unethical or avoidable. However, dual relationship situations might impair my objectivity, clinical judgment, or therapeutic effectiveness, thus will not be encouraged. If our paths should cross in public, I will not acknowledge you unless you initiate contact. It is preferred that you decide whether to disclose your acquaintance (therapist) to others. Please be aware that your counselor will not accept friend/follow requests from you on any social media sites in the interest of protecting your privacy as well as maintaining professional boundaries.

EMERGENCY SITUATIONS _____ (initial)
I desire to provide the highest level of care to clients both inside and outside of sessions. For scheduling and non-emergency situations, please contact me at 806-553-0534. In the event you encounter a personal emergency that will require prompt attention, my office will make every effort to accommodate an appointment. If your emergency arises after hours or on the weekend, clients are encouraged to contact a family member, call 911 or go directly to the nearest emergency department.

RISKS & BENEFITS _____ (initial)
It is agreed that the client shall make a good-faith effort at personal growth and engage in the counseling 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 for you and bring more life distress. Participation in therapy means that you accept these risks and are willing to deal with the potential problems that may surface. Suspension, termination, or referral shall be discussed for lack of commitment or any unresolved conflict or impasse between therapist and client as soon as possible.

MODIFICATION AND CONFLICT RESOLUTION _____ (initial)
It is agreed that any disputes or modifications of the 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 these methods of resolution are given a good faith effort and are unsatisfactory.

MINORS _____ (initial)
Minors must have parental consent for counseling with the exception that the client is: 16 years of age or older and resides apart from the parents/guardians and manages his/her financial affairs; is thinking about suicide; concerned about alcohol or drug addiction/dependency; or being sexually, physically, or emotionally abused. Consenting parents have the right to examine the treatment records of children under the age of 18. So that minors may have the trust of a protected environment, it is my practice to ask parents to forego that right (progress with the parent/guardian may be discussed) with the exception of extreme circumstances (see confidentiality below). It is important to note that in the state of Texas children under 17 may not have consensual sex (by law it is considered indecency with a child and therefore "child abuse") and the state requires me to breach confidentiality and report such activity to Child Protective Services. If I am required to make such a report to CPS about your child, you will be informed as well.

If the parents of the child receiving counseling are separated, divorced, or were never married, I need a copy of the Divorce Decree, Custody Decree, and other Court Orders affecting the rights of parents, guardians or others. I will need a copy of these papers **BEFORE** I can meet with your child. If I do not have the appropriate court orders, I will not be able to meet with your child for counseling. Depending on

the court orders, if I do not collect all the necessary signatures, I may have to refer you and the child to another mental health professional/therapist.

CONFIDENTIALITY _____ (initial)
Discussions between a therapist and a client are generally confidential and protected by law. 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: report of any suicide attempts or plan to attempt; incidences of "reasonably suspected child abuse" (physical or sexual); elderly or disabled abuse; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is an issue; situations where I have a duty to disclose, or where in my judgment, it is necessary to warn or disclose; fee disputes between myself and the client; negligence suit brought by the client against the therapist; and, filing of a complaint with the licensing or certifying board.

Complaints Management and Investigative Section
PO Box 141369
Austin, Texas 78714-1369

I may occasionally find it helpful to consult about a case with other professionals and if this should arise, your identity will not be revealed. In addition to your confidentiality being important to me, I am ethically bound to keep the information confidential. If you should meet a member of our staff and/or therapist in public, please know they will not acknowledge you unless you initiate contact. It is preferred that you decide whether to disclose your acquaintance to others. If you have any questions regarding confidentiality, you should bring them to my attention so that we can discuss this matter further. I hold confidentiality between clients in the highest regard and will make every effort to protect the information shared in our sessions together. By signing this Information and Consent Form, you are giving consent to Jessica Romero, 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.

DUTY TO WARN/DUTY TO PROTECT _____ (initial)
If the therapist believes that you (or your child, if the child is the client) are in any physical or emotional danger to yourself or another human being, you hereby specifically give consent to the therapist to contact any person who is in a position to prevent harm to you or another, including, but not limited to, the person in danger. You also give consent to your 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____

Please sign below to provide consent for the emergency contact person to be contacted in an emergency:

____
Client Signature (or Parent/Guardian if client is a minor) Date

Jessica Romero, M.A., LPC

Informed Consent Checklist

Please initial the following statements to acknowledge your understanding:

_______ You understand the limits of confidentiality as explained by the counselor and have had the opportunity to ask questions about these limits.

_______ You understand that the dynamics of your case may be discussed for staffing and continuing education requirements with the AFI staff.

_______ You understand the requirement for consultation for continuing education purposes do not otherwise affect your rights to confidentiality, which will be maintained within the limits of the law.

_______ You understand that you are not required to sign this document.

Provision of Consent

By signing below, you acknowledge that you have read the informed consent and are agreeing to adhere to its terms and conditions as you actively enter the therapeutic relationship. If the client is a minor, the parents/guardians of the client must also sign to provide proof of agreement that they, too, are entering the therapeutic relationship in the role of parent/guardian with the goal of seeking the best interest of the client.

Client Printed Name: ___________________________________

___

Signature (Client, if over the age of 18) Date

___

Signature (Parent/Legal Guardian #1) Date

___

Signature (Parent/Legal Guardian #2) Date

___

Signature of Therapist Date

HIPPA / HITECH ACKNOWLEDGEMENT OF RECEIPT

Printed Client's Name: ___________________________________

Client's Birth Date: ____/____/____

The Office of Jessica Romero, 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 806.350.3133 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: ___ / ___ / ___

Therapist Name: Jessica Romero, LPC

Signature of Therapist: __________________________________ Date: ___ / ___ / ___

APPLICABLE for MINOR

Client Printed Name: ___________________________________

Parent/Guardian Signature: ________________________________ Date: ___ / ___ / ___

Therapist Name: Jessica Romero, LPC

Signature of Therapist: __________________________________ Date: ___ / ___ / ___

Credit Card Authorization Form

Jessica Romero, M.A., LPC
Amarillo Family Institute

EFFECTIVE DATE: _____/_____/_____

I, ____________________________________ authorize the office of Jessica Romero, LPC to place a charge on my credit/debit card for the purpose of Therapy.

The agreed amount of **$130.00** will be charged per session.

I understand that in the event of a NO SHOW or LATE CANCELLATION, a session fee of the ***AGREED AMOUNT*** will be charged to my card.

CC: ____ ____ ____ ____ ____ ____ ____ ___ ___ ____ ____ ____ ____ ____ ____ ____

EXP DATE: ____ / ____ CVV: ____ ____ ____ ____ (3 or 4 digits) ZIP: ____ ____ ____ ____ ____

Would you like a monthly Flex Spending Sheet to use for insurance purposes? YES NO

____
Email Address / Phone # for provision of receipt

____
Card Holder's Signature Date

____
Therapist or Office Staff Date

Please call our office at 806-553-0534 between the hours of 9AM – 5 PM, Monday – Thursday if there are any questions or concerns regarding your account.