LENA POPE | Counseling Services

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Client Information Sheet

Today's Date: _____

CLIENT INFORMATION

Client Name: _____ **Client DOB**: _____

Sex: _____ **Marital Status**: _____ **Ethnicity**: _____

Last Grade Completed: _____ **Employer/School**: _____

Client's Soc. Sec. #: _____ **Parent/Guardian of Client**: _____

Insurance: _____ **Primary Card Holder Name & DOB**: _____

HOME ADDRESS

_____
Street **Apt #**

_____
City **State** **Zip Code**

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____ **Cell Phone Company**: _____

May we contact you by email/text? Yes No

ANNUAL HOUSEHOLD INCOME

☐ Less than 20,750 ☐ 20,750 – 34,599 ☐ 34,600 – 55,349 ☐ 55,350 +

PLEASE LIST ALL INDIVIDUALS LIVING IN THE HOME:

Full Name	DOB	Sex	Ethnicity	Marital Status	Relationship To Client	Last Grade Completed	Employer/School

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What is your goal for counseling? _____

_____

_____

EMERGENCY CONTACT

In the event of an emergency, I authorize Lena Pope to contact the following individual.

Name:_____ Address:_____
Phone:_____ Relationship:_____

Please Initial _____

GENERAL INFORMATION AND CONSENT FOR TREATMENT OF SELF OR OF MINOR CHILD

It is our belief that we can establish a better relationship and serve you more effectively if you are familiar with the procedures of this program. We believe in continuous improvement in the quality of services that are provided at Lena Pope and may ask you to assist us by completing a satisfaction survey. These are available at the front desk. Please be advised that a staff person may be calling you after counseling services has ended for follow-up and aftercare.

If enrolling a minor child for services at Lena Pope, please provide the following information:

Birth Mother Name: _____Birth Father Name: _____

_____

Appointments And Scheduling

Based on the need and the assigned program, clients are seen in the office, home, or community. Lena Pope acknowledges the value of Emotional Support Animals (ESAs), however ESAs are not allowed in any Lena Pope offices. Individual appointments are generally fifty-minute sessions. Groups are typically 90 minutes. To contact someone about rescheduling or cancelling an appointment call **(817) 255-2652 for Counseling Services**. All telephone calls will be returned as soon as possible. **Arriving more than 15 minutes late for a session may result in loss of your appointment.**
We ask that you call our office at least 24 hours in advance if you need to cancel or reschedule. There is a $25 fee for missed appointments, as well as appointments cancelled with less than 24 hours' notice. Individuals who miss two appointments without prior notification during treatment are subject to removal from the appointment calendar.
In case of bad weather, your therapist will call if the office closes and your appointment needs to be rescheduled.
If you have a medical emergency, call 911. If you feel a non-medical emergency exists and it is after office hours, please call your county's Hotline Number listed: Tarrant County 1-800-866-2465 or text 817-335-3022 and for Hood / Parker Crisis Hotline 1-800-772-5987

Confidentiality

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Lena Pope staff take every reasonable measure to ensure your confidentiality. However, confidentiality and privileged communication are limited under Texas law and professional codes of ethics. Lena Pope staff are required to report any suspicions or evidence of child abuse; abuse of those who are elderly or disabled; a person's intent to take harmful, dangerous, or criminal actions against another human being or against him/herself; and sexual exploitation by a mental health provider.

Philosophy

The practice of counseling requires mutual understanding, respect, and confidence. We look forward to providing you services with the highest professional standards of counseling. Lena Pope uses evidence-based practices and programs. Depending on the program that you are enrolled in, services can include screenings, assessments, individual, family, couples, group counseling, school or community-based groups, and in-home counseling. Your therapist will discuss his or her personal method of treatment and will help you decide on goals for your treatment.

Your therapist will help you decide if including family members or significant others in your treatment will assist you in reaching your goals. It is also important to understand that participation in counseling can lead to individual changes that could affect your relationships and interactions with others in both positive and negative ways. If you wish, your therapist can discuss alternate forms of treatment for your concerns.

CLIENT BILL OF RIGHTS

Each Lena Pope program shall respect and protect client's rights. As a client of Lena Pope, you have a right to the following:

1. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
2. You have the right to be free from abuse, neglect, and exploitation.
3. You have the right to be treated with dignity and respect.
4. You have the right to receive services that is culturally responsive to your individual and/or family's needs.
5. You have the right to appropriate treatment in the least restrictive setting available that meets your needs.
6. You have the right to be told about the program's rules and regulations before participating in treatment, including, without limitation, the rules and policies related to restraints and seclusion. Your legally authorized representative, if any, also has the right to be and shall be notified of the rules and policies related to restraints and seclusions.
7. You have the right to be told before participating in treatment:
    a. the condition to be treated;
    b. the proposed treatment;
    c. the risks, benefits, and side effects of all proposed treatment;
    d. the probable health and mental health consequences of refusing treatment; and
    e. other treatments that are available and which ones, if any might be appropriate for you;
    f. the expected length of stay.
8. You have the right to refuse or accept treatment after receiving this explanation.

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9. If you agree to treatment, you have the right to change your mind at any time (unless specifically restricted by law).
10. You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
11. You have the right to meet with staff to review and update the plan on a regular basis.
12. You have the right to refuse to take part in research without affecting your regular care.
13. You have the right not to be restrained unless you are a danger to yourself or others.
14. You have the right to have information about you kept private and to be told about times when the information can be released without your permission.
15. You have the right to be told in advance of all estimated charges and any limitations on the length of services that the facility is aware of.
16. You have the right to receive an explanation of your treatment or your rights if you have questions while you are in treatment.
17. You have the right to make a complaint and receive a fair response from the facility within a reasonable amount of time.
18. You have the right to complain directly to the Texas Department of State Health Services at any reasonable time.
19. You have the right to get a copy of these rights before you are admitted, including the address and phone number of the Texas Department of State Health Services.
20. You have the right to have your rights explained to you in simple terms, in a way you can understand within 24 hours of being admitted.

GRIEVANCE PROCEDURES

I was informed that I have the right to file a complaint or grievance about any problem that I may wish to have addressed.

I understand no one can punish, threaten, or discriminate against me for using or helping someone else file a complaint or grievance.
I understand that if I am not satisfied with any decision regarding my complaint, that I have the right to appeal the decision to the next highest level and to the Executive Director of Lena Pope.
The following is a list of steps of the grievance process:

a. Any client may request a Grievance Form from any Counseling Services staff member in-person or by calling (817) 255-2652 for Counseling Services.
b. Any client may request and will be provided writing materials, postage, access to a telephone for the purpose of filing, and/or assistance in completing the form from a Counseling Services staff member.
c. Any client may submit a completed and signed form to the Counseling Services Supervisor or Director. A copy of the form will be provided to the Executive Director and Director of Human Resources. If there is an issue that requires more immediate attention, additional copies of the form will be distributed to the appropriate individuals as soon as possible.
d. The Counseling Services Supervisor or Director will evaluate the grievance thoroughly and objectively, obtain additional information as needed, and respond to the client with the proposed resolution(s) within seven (7) business days.
e. The Counseling Services Supervisor or Director will document the grievance process and a copy of the form, resolution(s), and outcome(s) will be sent to the Executive Offices.

f. Documentation of all grievances will be maintained in a central file in the Counseling Services Department.
g. Any client may file the grievance directly with the Texas Behavioral Health Executive Council. (Texas Administrative Code §884.31(b))

Notice To Clients

The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint.

Texas Behavioral Health Executive Council
333 Guadalupe St., Tower 3, Room 900, Austin, Texas 78701
1-800-821-3205 toll-free

CONSENT TO BILL INSURANCE AND PAYMENT RESPONSIBILITY

Fees

If you have eligible insurance coverage, we will submit claims on your behalf. **Those who have Medicaid coverage are required to present a Medicaid card at each visit.** If you do not have insurance, financial assistance may be available and is determined based on family size and income level (proof of income is required). There is a $25 charge applied for returned checks.

All fees/co-pays are due at the time services are provided.

I understand that information disclosed pursuant to this consent may be re-disclosed by the recipient of the information. Most health care providers and all health benefit plans are obligated to follow federal rules and state laws for protection of the privacy of your health information, but those rules and laws do not apply to all organizations.

I understand that there is no time limit on this consent. I also understand that I may revoke this consent at any time.

I am the person who is the subject of the health records that will be used or disclosed, or I have the legal right to consent for that person. I agree to the use and disclosure of health information as described in this consent.

I understand that the services or items that I have requested to be provided to me may not be considered by my insurance as being reasonable and medically necessary for my care. I understand that the insurance company determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

I understand if Lena Pope provides services that are not covered by insurance that I will be responsible for the fees for such services.

I understand that the standard fee(s) of $150 per diagnostic assessment, $100 per individual counseling session and/or $40 per group counseling session provided by Lena Pope Counseling Services.

I agree that if my financial situation changes or insurance coverage ends during the time services are being provided that I will begin paying the standard fee(s) according to the financial assistance scale.

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TELEMENTAL HEALTH INFORMED CONSENT FOR TREATMENT OF SELF OR OF MINOR CHILD

As a client or patient receiving mental services through telemental health technologies, I understand:

1. Telemental health is the delivery of mental health services using interactive technologies (use of audio, video or other electronic communications) between a therapist and a client who are not in the same physical location.
2. Electronic systems used will incorporate network and software security protocols to protect the privacy and security of mental health information and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Benefits & Limitations

3. This service is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face to face communication. There are benefits and limitations to this service.
4. Regardless of the sophistication of today's technology, some information a therapist would ordinarily utilize in in-person sessions may not be available in telemental health sessions. I understand that such missing information could, in some situations, make it more difficult for a therapist to understand my problems and to help me.
5. Telemental health services may not be covered by insurance. ***During the COVID-19 disruption, most insurance companies have agreed to pay for telemental health as they would for in-person sessions. Should you have questions about your specific insurance company's policy, please reach out to them directly.***

Risks of Technology

6. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.
7. I understand that telemental health is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet known.
8. Among the risks that are presently known is the possibilities that the technology will fail before or during the sessions, that the transmitted information in any form will be unclear or inadequate for proper use in the sessions, and/or that the information will be intercepted by an unauthorized person or persons.
9. In rare instances, security protocols could fail, causing a breach of privacy of personal health information.
10. I understand that if I enter private information on a public access or shared computer or network, it is possible that it can be accessed by other people. I should ensure the equipment I am using is private.
11. "Auto-remember" of usernames and passwords should not be used when using telemental

health services.

Technology Requirements

12. I understand that I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.

Exchange of Information

13. The exchange of information will not be physical, and any paperwork exchanged will likely be provided through electronic means or through postal delivery.
14. During my telemental health sessions, details of my medical history and personal mental health information may be discussed with myself or other mental health care professionals through the use of interactive video, audio or other telecommunications technology.

Local Practitioners

15. If a need for direct, in-person services arises, it is my responsibility to contact my therapist's office for an in-person appointment, or my primary care physician if my therapist is unavailable. I understand that an opening may not be immediately available in either office.

Discontinuing Care

16. I understand that at any time, the sessions can be discontinued either by me or by my designee or by my mental health care provider.
17. I further understand that I do not have to answer any question that I feel is inappropriate or that I do not wish persons present to hear; and that any refusal to participate in the sessions or use of technology will not affect my continued treatment; and that no action will be taken against me based upon such refusal to participate.
18. I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly. If that occurs, my telemental health-based treatment might be less successful than it otherwise would be, or it could fail entirely.
19. I may decline any telemental health services at any time without jeopardizing my access to future care, services, and benefits.

Modification Plan

20. My therapist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of telemental health, and modify our plan as needed.

Emergency Protocol

21. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means.
22. In emergency situations: My therapist will attempt to communicate with me via phone, text and/or email.

Disruption of Service

23. Should service be disrupted: ____My therapist will immediately call me back. If I am not able to

answer, my therapist will use other communication means to ensure you are safe (i.e. text, email.) and services are delivered effectively.

Therapist Communication

24. My therapist may utilize alternative means of communication in the following circumstances: disruption in cell service, you not answering phone calls, disruption in video/audio equipment or internet service
25. My therapist will respond to communications and routine messages within 24 HOURS.

Client Communication

26. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.
27. I will take the following precautions to ensure that my communications are directed only to my therapist or other designated individuals: I will participate in session from a private location, wear headphones/earbuds, angle screen out of view of others, etc.

Records and Web Maintenance

28. My therapist will maintain electronic records in accordance with relevant laws and statutes. This includes, but is not limited to, the type of encryption and security assigned to the records, and if/for how long the archival storage of records are maintained.
29. My communication exchanged with my therapist will be stored in the following manner:

    My therapist will use a secure and password protected agency network, electronic records system, and electronic devices.

Laws & Standards

30. The laws and professional standards that apply to in-person mental health services also apply to telemental health. These can be found at https://www.bhec.texas.gov/statues-and-rules/index.html
31. Please note, included in these laws & standards is the following: telemental health can only be performed when the client is in the state of their residence and in which the therapist is licensed- in this case Texas. Therapists cannot hold a therapy session if I am outside of the state of Texas.

Mobile Application

32. My private health information may be transmitted from my practitioner's mobile device to my own or from my device to that of my practitioner via an 'application" (abbreviated as "app").
33. I understand that a variety of alternative methods of mental health care may be available to me, and that I may choose one or more of these at any time. My mental health care provider has explained the alternative to my satisfaction.

Equipment

34. I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I understand the risk

that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

Identification

35. I understand that I will be informed of the identities of all parties present during the sessions or who have access to my personal mental health information and of the purpose for such individuals to have such access as referenced in the Receipt of Privacy Practices I was provided.

Telemental Health Process

36. My therapist has explained how the telemental health sessions are performed and how they will be used for my treatment. My therapist also explained how the sessions will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.
37. There is potential for misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically. My therapist will address this with me individually.
38. My therapist will verify my identity if using audio-only services. An individualized ID number will be given to me, and my therapist will ask for me to give him/her that number to verify my identity at the beginning of each session.

Additional Services

39. I understand that it is my duty to inform my therapist of electronic interactions regarding my care that I may have with other mental health care providers.

Electronic Presence

40. In brief, I understand that my therapist will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter into an "app" will be transmitted electronically to and from myself and my therapist.

Release of Information

41. I authorize the release of any information pertaining to me determined by my therapist, my other health care practitioners or by my insurance carrier to be relevant to the sessions or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information to my insurance company.

Limits of Confidentiality

42. I also understand that, under the law, and regardless of what form of communication I use in working with my therapist, my therapist may be required to report to law enforcement authorities information suggesting that I have engaged in behaviors that endanger myself or others.

Alternatives

43. The alternatives to the telemental health sessions have been explained to me, including their risks and benefits, as well as the risks and benefits of going without treatment. I understand

that I can still pursue in-person sessions. I understand that the telemental health sessions do not necessarily eliminate my need to see a therapist in person, and I have received no guarantee as to the telemental health sessions' effectiveness.

Records

44. I understand that my telemental health sessions may be recorded and stored electronically as part of my medical records. I understand that sessions and disclosures will be held in confidence subject to state and/or federal law.
45. I understand that I am ordinarily guaranteed access to my records and that copies of my records are available to me on my written request.
46. I also understand, however, that if my therapist, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy.

Contact Information

47. I have received a copy of my therapist's contact information, including his or her name, telephone number, voice mail number, business address, mailing address, and e-mail address.

Emergency Care

48. I acknowledge that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person, I am not to seek a telemental health session. Instead, I agree to seek care immediately through my own local health care provider or at the nearest hospital emergency department or by calling 911.
49. I am aware that my therapist may contact the proper authorities and/or my designated, local contact person in case of an emergency.
50. This are the name and telephone number of my local mental health emergency contacts.

MHMR iCARE Hotline
1-800-866-2464 Text or Call

Release of Liability

51. I unconditionally release and discharge Lena Pope Home, Inc, its affiliates, agents, and employees any liability in connection with my participation in the remote sessions.

Final Agreement

52. I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers.
53. With this knowledge, I voluntarily consent to participate in the telemental health sessions, including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

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CLIENT ACKNOWLEDGEMENTS

I acknowledge that I have received and reviewed the following documents (initial):

_____ Notice of Privacy Practices

_____General Information and Consent for Treatment of Self or of Minor Child

_____Client Bill of Rights

_____Grievance Procedures

_____Consent to Bill Insurance and Payment Responsibility

_____Telemental Health Informed Consent for Treatment Of Self Or Of Minor Child

My signature affirms that I have read or heard the information above and that it was presented to me in clear, non-technical language. This information is understood by me and enables me to make an informed voluntary consent to counseling for myself and/or the child named below.

Client Name: _____ **Client DOB:** _____

Signature of Client or Parent/Guardian/Representative:

_____

Printed Name of Parent/Guardian/Representative:

_____

Date: _____