

Janae McClure
Graduate Student Intern
Supervised by Leslie Bley, LPC-S
4220 Monterey Oaks Blvd
Austin, TX 78749

CLIENT INFORMATION

Name _____ Phone _____

Address _____ City _____

State _____ Zip _____ Birth Date ____/____/____ M / F Other: _____

Email: _____ Ethnicity: _____

May I leave text & voice msgs with the phone number listed? Please initial _____ Yes _____ No

I would like an email reminder 48 hours before session Please initial _____ Yes _____ No

I would like a text reminder 24 hours before session Please initial _____ Yes _____ No

Single Married Widowed Separated Divorced # _____ children # _____ years married

Medications currently taking including vitamins and supplements: _____

Employment (circle): Full-time Part-time Unemployed/Minor At home with children

Occupation: _____

Name and Phone # for Emergency 1) _____

2) _____

Which format do you prefer: _____ In office _____ Telehealth

In a few words, describe what has brought you to counseling?

What do you hope to gain or accomplish through counseling?

What are your hobbies and interests? _____

How do you think others would describe you? _____

What words would you use to describe you? Please list at least 5. _____

Spirituality and Religion

If you feel comfortable sharing, is there a religion or spirituality you adhere to?

Do you attend a church/temple/synagogue/ or other place of worship/spiritual practice and if so, what is the name of it? _____

Are you interested in bringing your religious/spiritual practices/beliefs into our sessions?

_____ Yes _____ No _____ Maybe

How important is your spirituality/religion to your daily life? _____

Military History - If Applicable

Are you currently or formerly a military member or spouse of military? _____

If yes, please describe: _____

Mental Health History

Have you ever suffered sexual abuse of any kind (rape, incest, molestation, fondling, unwanted sexual advances, other, etc.)?

_____ Yes _____ No _____ Maybe

Have you ever suffered physical, emotional, verbal, or spiritual abuse? If so, please specify which one(s): _____

Have you ever received mental health counseling in the past? _____ Yes _____ No

If so, please describe your experience. _____

Harm to Self or Others

Do you currently fear for your life or the life of someone close to you? _____ Yes _____ No

Have you ever seriously considered suicide or attempted suicide? _____ Yes _____ No

Do you have a plan and way to commit suicide now? _____ Yes _____ No

Do you have the intent and means to kill someone other than yourself right now? _____ Yes _____ No

Physical Health History

Do you have any health conditions or diagnosed illnesses/syndromes? _____

Do you or have you used any of the following substances:

Tobacco: Y or N How Often? _____

Alcohol: Y or N How Often? _____

Marijuana: Y or N How Often? _____

Illegal Drugs Y or N How Often? _____

Do you struggle with any addictions like food, gambling, drugs, pornography, shopping, etc.?

Are you currently experiencing any physical pain or symptoms in your body, and if so what and where?

Describe your daily nutrition habits: _____

How many hours do you sleep a night? _____ Quality? _____

Do you exercise regularly? Y or N

If yes, explain your routine: _____

Any other physical/health related information you want to share? _____

COMMUNICATION/PAYMENT CONSENT [please initial to consent]

_____ I grant permission to send and receive communication from my therapist at the following email address _____.

_____ I grant permission to conduct counseling sessions via Telehealth platforms if beneficial.

_____ I recognize that email and other forms of Internet/web-based communication are not a secure/confidential means to transmit data. By initialing here, I voluntarily waive my rights provided by the HIPAA law, and any other federal or state laws regarding confidentiality and the transmission of information via the Internet. I voluntarily give my permission and will not hold Janae McClure Graduate Intern and/or Leslie Bley, LPC-S legally responsible for the transmission of this data.

_____ I give permission to Janae McClure Graduate Intern to use general information about our therapeutic work for private consultation with her Supervisor and/or professional mentors for the well-being of our work.

_____ I understand that Leslie Bley, LPC-S and her staff do not engage in social media. Our counselors may have private social media accounts, but will not engage with clients on those accounts.

_____ I give permission to Janae McClure Graduate Intern to allow faith-based counsel in our sessions if that is something I desire as a part of our therapeutic relationship.

_____ I understand that all payments are to be made to Leslie Bley. I authorize Leslie Bley to collect counseling fees as well as charge session fees if there is a credit card on file.

_____ I authorize Leslie Bley to keep a credit card on file. Name on Card: _____

CC #: _____ Exp: ____/____ CVV: _____ Zip: _____

EMERGENCIES

In case of an emergency, you can contact me at 512-808-0497 between 7am-7pm, M-F. I will do my best to schedule a same day/week appointment. In case of a dire emergency after hours or on weekend (ex: mental health crisis, suicide attempt, overdose, etc.) please call 911. You may also call the National Suicide Lifeline in case of a suicidal emergency: 800-273-8255.

APPOINTMENTS & FEES

Sessions are typically 50 minutes. My rate is \$50 per session made payable to Leslie Bley and is expected upon service. Cash, check, and credit cards accepted. Cancellations under 24 hours before session and/or missed appointments may be charged a \$25 fee.

Education

Janae McClure graduated with a Bachelor of Science degree in Psychology from Texas A & M University in August of 1998. Just out of college, I worked at Helping Hand Home for Children, a residential treatment center in Austin, Texas, for children that were wards of the state. I served as a parental figure to four teen girls as they were waiting to be adopted and supported them in their schooling, for court hearings, doctor/dentist visits, and making sure they were attending regularly scheduled counseling sessions with a licensed counselor onsite. In 1999, I moved with my husband to Los Angeles, California and worked under Dr. Deryl Goldenberg, PhD with the Verdugo Hills Autism Project and was trained as an Applied Behavior Analysis (ABA) therapist for children with autism. We moved back to Texas the following year and I worked as a preschool teacher for several years as I was raising my own babies. In 2020, I entered graduate school at Colorado Christian University to pursue a life-long dream to become a mental health counselor. I am currently a practicum/intern student under Leslie Bley, LPC-S in Austin, Texas, working with adult and child survivors of sexual abuse, major trauma, autism spectrum disorders, brain injury survivors, as well as clients with attachment and adjustment issues. I plan to matriculate in May of 2024.

Risks of Counseling

Often in counseling when confronting tough issues or changes, things can seem to get worse before they get better. This is a common and expected part of the healing process. New issues may arise during our discussions that you did not originally intend to talk about. This is also normal, as we are complex beings with many challenges that can be interconnected through mind, body, and spirit. I am here to walk alongside you through all of it to help you learn to thrive and embrace wellness.

Diagnosis

Our staff does not accept insurance. Some insurance companies will reimburse clients for out-of-network counseling services, but it is up to you to file with your company. Most insurance carriers require a diagnosis of a mental health condition in order to provide coverage. Some reasons clients pursue services do not qualify for a diagnosis, even though there is a legitimate need to seek help. If there is a diagnosis, I will inform you of that before you submit your information to insurance and this diagnosis will become part of your permanent insurance record.

Consent to Treatment and Recipient's Rights

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above to receive treatment by Janae McClure Graduate Intern. I understand that the therapy may be discontinued at any time by either party, however, it is encouraged that this decision be discussed with the treating psychotherapist prior to discharge. Janae is supervised by Leslie Bley, LPC-S.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the Counselor is protected by Federal and/or State law and regulations. Generally, the Counselor may not say to a person outside the Center that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Counselor's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original.

I consent to treatment and agree to abide by the above stated policies and agreements with Janae McClure Graduate Intern.

Signature of Client/Legal Guardian
(In a case where a client is under 18 years of age,
a legally responsible adult acting on his/her behalf)

Date

JANAE MCCLURE - GRADUATE STUDENT INTERN SUPERVISED BY LESLIE BLEY, LPC-S

Notice of Privacy Practices

Our Commitment to you and your privacy

This notice describes how information about you may be used and disclosed and how you can get access to it. HIPAA stands for the Health Insurance Portability and Accountability Act and was passed because of concerns in an age of electronic records. It is important to us you understand our policies and your rights to safeguard your protected health information (PHI). Some of this information is duplicated on the Standards and Policies.

Uses and Disclosures

We may use or disclose your protected health information (PHI) for treatment, payment, and health care purposes with your consent.

- PHI: information in your health records that could identify you
- Treatment: medical or mental health care provided to you by a physician or therapist
- Payment: to obtain payment for services we provide to you
- Health Care Operations: include quality assessment, business audits, administrative, case management and care coordination
- Use: activities within our practice such as examining and analyzing information that identifies you
- Disclosure: activities outside our practice such as releasing, transferring, or providing access to information about you to other parties

Use of Technology

Email and/or Texting is not a preferred type of communication but if you choose to email and/or Text, your information is not guaranteed to be protected. Your counselor may not respond to any emails until in person within your scheduled session. Emails may contain PHI and email does not meet the necessary security requirements used to protect confidentiality. Email is NOT for emergencies.

Uses and Disclosures Requiring Authorization/Release

We may use or disclose your PHI when your authorization and signed release is obtained for these specific disclosures. Psychotherapy notes have a greater legal protection than your PHI and will not be released without your consent. As a client you may revoke all authorizations at any time, provided each revocation is in writing. You may not revoke authorization if the authorization has already been obtained and acted on or if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest under the policy.

Uses and Disclosures with neither Consent Nor Authorization

We may use or disclose your PHI without your consent or authorization as required by law in the following circumstances:

- Child abuse: if we have cause to believe a child has been or may be abused, neglected, we are required by law to report it within 48 hours to the proper authorities
- Elderly or Disabled Person Abuse: if we have cause to believe that an elderly or disabled person has been or may be abused, neglected, or exploited, we are required to report it to the proper authorities
- Health Oversight: if a complaint is filed against us with the State Board of Examiners, they have the authority to subpoena confidential mental health information that is relevant to the complaint
- Judicial or Administrative Proceedings: if you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged and will not be released without written authorization. This does not apply when you are being evaluated for a third party or where the evaluation is court ordered.
- Serious Threat to Health or Safety: if we determine there is a probability of physical injury to yourself or others, or probability of such, we may disclose relevant confidential mental health information to medical or law enforcement personnel.

Clients Rights and Responsibilities

- You agree to responsibly participate actively in the process of therapy both in sessions and between sessions, and you also agree to be honest with your therapist
- You agree to arrive on time for sessions and pay for services received
- You agree to notify your counselor if you become unable to attend sessions and if you do not cancel within less than 24 hours, you agree to possibly pay a half charge for the session
- You have the right to request restrictions on certain uses and disclosures of protected health information. However we are not required to agree to a requested restriction.
- You have the right to request and receive confidential communications of PHI by alternative means and at an alternate location (i.e. bills sent to an alternative address).
- You have the right to inspect a copy of your PHI. Psychotherapy notes that are kept separate from PHI are protected.
- You have the right to request an amendment of PHI for as long as the PHI is maintained in your record. The request may be denied but the details will be discussed.
- You generally have the right to request an accounting of disclosures of PHI for which you have neither provided consent nor authorization.
- You have the right to obtain a paper copy of this notice.

Therapists Duties

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We are required by law and state board code of ethics to break confidentiality if any of the above listed circumstances occur.
- We reserve the right to change the privacy policies and practices described in this document after notification.
- If revisions to policies and procedures occur, you will be notified and provided with a copy.
- Most therapists at Streams are not providers of insurance but will provide a needed diagnosis code for you to file with your insurance. Any diagnosis will become part of your permanent record.
- We will take care to practice within our individual level of competence and licensure.
- We will discuss the how's and why's of any suggested interventions within the therapy process.
- We will refer you to other professionals at any time you request.

Complaints

We encourage you to bring your concerns directly to your therapist or a supervisor on site. If you feel you are not getting adequate responses from direct interactions, you may file a complaint against a Licensed Professional Counselor by contacting the Texas State Board: *Complaints Management and Investigative Section P.O. Box 141369 Austin, Texas 78714-1369* or *1-800-942-5540* to request the form or obtain information.

Acknowledgement of Receipt of Privacy Policies Notice

- I have received a copy of the privacy policies documented above

Client—Print Name

Client (if more than one)—Print Name

Client—Signature

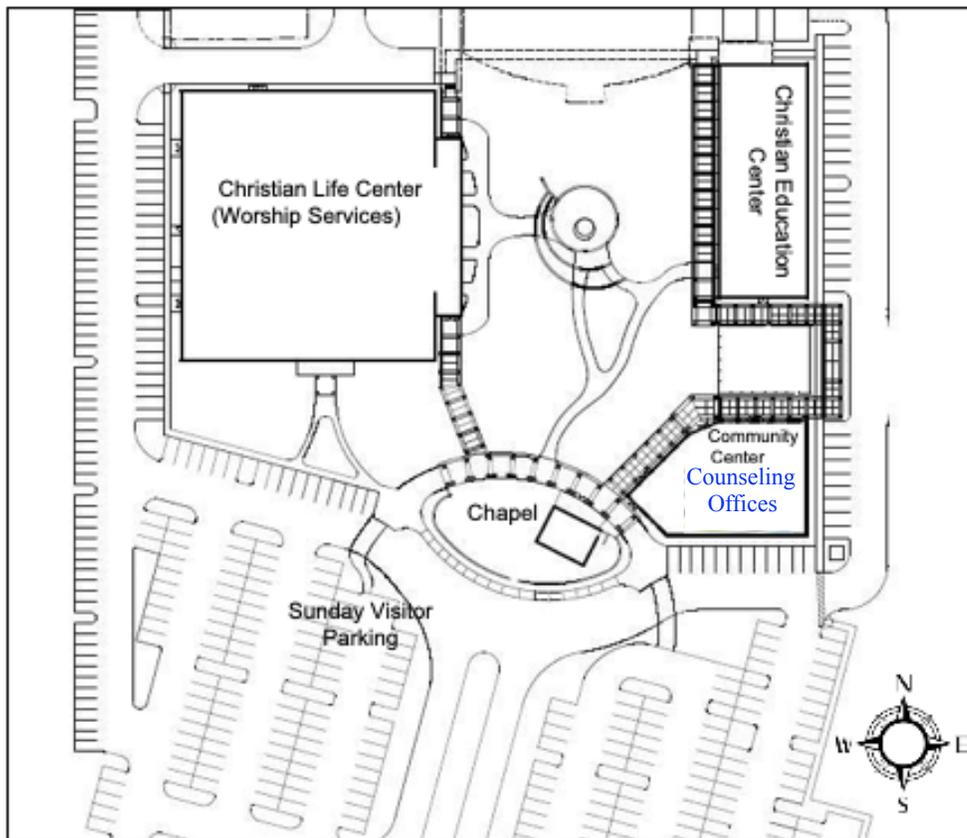
Client (if more than one)—Signature

Date

**STREAMS COUNSELING CENTER AT
AUSTIN OAKS CHURCH**

4220 MONTEREY OAKS BLVD
AUSTIN, TX, 78745
512-891-1600 (AOC receptionist)

When you arrive, please come to the 3rd floor of the Community Center.
There is a waiting area near the counseling offices to your right after getting
off the elevator. I will come greet you at the time of our appointment.



To MOPAC (Loop 1) Access Road

To Monterey Oaks Boulevard