Peace of Mind Counseling
Melissa Earls, Ed. D., LPC-S, RPT-S
When you need someone who wants to listen

ADULT INFORMATION/CONSENT FORM

Patient's Name: _____

Today's Date: _____

Birthdate: _____ Age: _____ Soc. Sec. #: _____

Male __ Female __ Single _Married _ Divorced __ Dating __Separated __ Widowed __ Life Partners ___

Address: _____
City, State, Zip

Occupation: _____

Best Contact Phone: _____ Email: _____

If there is emergency at the office and we must cancel the appointment, where should we call:
_____
In the event of an emergency with you, whom should we contact:
Name: _____ Relationship: _____

Best Contact Phone: _____
Who is responsible for this account/ Who is the Insured?
Name: _____ Relationship to Patient: _____

Birthdate: _____Soc. Sec. # _____

Insurance number:_____ Group Number:_____

Insurance Management Company:_____

Insurance Phone Number for Behavioral Health:_____

Address: _____
City, State, Zip

Employer: _____

Authorization and Release: **I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.** I give Melissa Earls LPC the right to seek the services of a bill-collecting agency in efforts to collect fees that my insurance company has not paid and that I have not paid to him for services rendered and/or for cancelled or missed appointments.

X_____/_____
Signature of patient or parent if minor /Date

3331 Cartwright Rd., STE 125, Missouri City, TX. 77459 *Office*
PO Box 376, Fresno, TX. 77545 *Mailing*
281.788.7975 *Contact*
281.407.6217 fax
www.peaceofmindcounseling.org
peaceofmindcounseling@yahoo.com *email*

Where did you attend public school? _____
Did you attend college? When, where? _____
Any plans to further your education? _____ If so, when and what? _____

About Your Relationships: Please list your marriage(s) or other important significant other relationships
Spouse's name Year Begun Year Ended Married to this person?
Children from this relationship and their ages
#1 _____
#2 _____
#3 _____

Please list all people who live with you
_____
_____
_____
_____

About Your Family:
Relative Name Living? _____
Current age, or age at death Deceased? _____
Yes or No Occupation _____
Father Mother Brother(s) Sister(s) Any other significant person?

About Your Health: Who is your Doctor? _____ Last Visit: _____ Concerns? _____ Do you have any chronic medical concerns? _____. If so, please list: _____ List all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had: _____ List *all* medications or drugs (legal or illegal) you take or have taken in the last year.
_____
_____

ALL ABOUT YOU About Your Education:
_____
_____
_____
_____
_____
_____
_____.

ABOUT YOUR CONCERNS
Please mark all of the items below that currently apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ☐ Abuse-emotional
- ☐ Abuse-neglect
- ☐ Abuse-physical
- ☐ Abuse-sexual
- ☐ Aggression
- ☐ Anger
- ☐ Anxiety
- ☐ Arguing
- ☐ Attention Problems
- ☐ Career concerns
- ☐ Childhood issues (your own childhood)
- ☐ Children-care
- ☐ Children-custody
- ☐ Children-management
- ☐ Choices I have made
- ☐ Codependence
- ☐ Compulsions
- ☐ Compulsive spending
- ☐ Concentration Problems
- ☐ Confusion
- ☐ Crying
- ☐ Deaths
- ☐ Debt
- ☐ Decision making
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression
- ☐ Distractibility
- ☐ Divorce
- ☐ Drug Abuse-over-the-counter medications
- ☐ Drug Abuse-prescription medications
- ☐ Drug Abuse-street drugs
- ☐ Drug Abuse-Alcohol
- ☐ Eating-poor appetite
- ☐ Eating-making myself vomit

- ☐ Eating-overeating
- ☐ Eating-under-eating
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue
- ☐ Fears
- ☐ Financial troubles
- ☐ Friendship problems
- ☐ Gambling
- ☐ Goals not being met
- ☐ Grieving
- ☐ Guilt
- ☐ Headaches, pains
- ☐ Health
- ☐ Hostility
- ☐ Impulsive spending
- ☐ Impulsiveness
- ☐ Indecision
- ☐ Inferiority feelings
- ☐ Inhibitions
- ☐ Interpersonal conflicts
- ☐ Irresponsibility
- ☐ Irritability
- ☐ Judgment problems
- ☐ Laziness
- ☐ Legal matters
- ☐ Loneliness
- ☐ Loss of control
- ☐ Losses
- ☐ Low energy
- ☐ Low frustration tolerance
- ☐ Low income
- ☐ Low mood
- ☐ Marital coldness
- ☐ Marital conflict
- ☐ Marital distance
- ☐ Marital infidelity/affairs
- ☐ Medical concerns
- ☐ Memory problems
- ☐ Menopause
- ☐ Menstrual problems
- ☐ Mixed feelings
- ☐ Mood swings
- ☐ Motivation
- ☐ Mourning
- ☐ Obsessions
- ☐ Outbursts
- ☐ Oversensitive to criticism
- ☐ Over-sensitive to rejection
- ☐ Panic or anxiety attacks
- ☐ Parenting
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Phobias
- ☐ Physical problems
- ☐ PMS
- ☐ Poor self-care
- ☐ Procrastination
- ☐ Relationship problems
- ☐ Relaxation
- ☐ Re-marriage
- ☐ Risk taking
- ☐ Sadness
- ☐ School problems
- ☐ Self Abuse-burning
- ☐ Self Abuse-cutting
- ☐ Self Abuse-other
- ☐ Self Abuse-scratching
- ☐ Self-centeredness
- ☐ Self-control
- ☐ Self-esteem
- ☐ Self-neglect
- ☐ Separation
- ☐ Sexual conflicts
- ☐ Sexual desire differences
- ☐ Sexual dysfunctions
- ☐ Sexual-(other issues)
- ☐ Shyness
- ☐ Sleep-insomnia
- ☐ Sleep-nightmares
- ☐ Sleep-too little
- ☐ Sleep-too much
- ☐ Step parenting
- ☐ Stress
- ☐ Stress management
- ☐ Suicidal thoughts
- ☐ Suspiciousness
- ☐ Temper problems
- ☐ Tension/Stress
- ☐ Thought disorganization
- ☐ Threats of violence
- ☐ Tiredness
- ☐ Tobacco use
- ☐ Violence
- ☐ Work Problems
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Employment problems
- ☐ Employment-lack of
- ☐ Employment-overdoing
- ☐ Employment-Terminations
- ☐ Other Concerns: _____

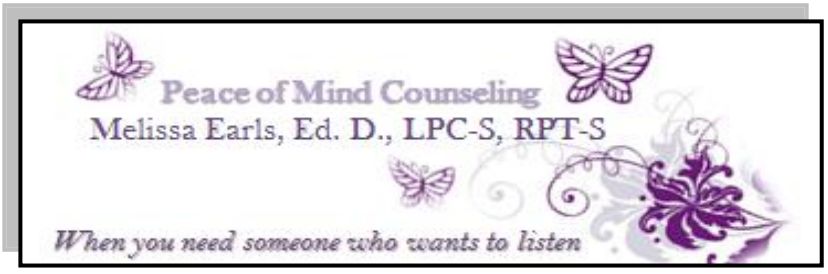
_____

_____

_____

_____

_____



Acknowledgement of Receipt of Disclosure, Consent & of Notice of Privacy Practices Form for Melissa Earls, LPC

- I understand that **Melissa Earls, LPC** is a Licensed Professional Counselor in the state of Texas and holds a B.A. in History and Sociology and an M.A. in Psychology from Houston Baptist University, Texas and has earned a Doctorate in Education in the Field of Counseling from Texas Southern University.
- I understand that **Melissa Earls, LPC** works with children, adolescents, and adults in individual, group, and family counseling.
- I understand that as my therapist, or the therapist working with my child, I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.
- I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed in that assignment.
- I understand that if I am concerned about slow progress or lack of progress I have the right to speak to **Melissa Earls, LPC** about this.
- I understand that **Melissa Earls, LPC** does perform formal testing but may refer individuals for additional testing.
- I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.
- I understand that there are some occasions when confidentiality can/must be breached. Those are: **a*) I direct Melissa Earls LPC to tell someone else in writing or verbally, b) Melissa Earls LPC determines that his client poses a threat to them self or others, c) he is ordered by a court to disclose information, or d) He suspects that child abuse has taken place, at which time he will notify Child Protective Services.***
- I understand that counseling can improve as well as upset the equilibrium in any person or family.
- I understand that if I have a complaint I cannot resolve with **Melissa Earls, LPC** and I wish to file a formal complaint I may contact the **Texas State Board of Examiners of Licensed Professional Counselors** at 1-800-942-5540.
- I understand I am responsible for all fees that my insurance denies, rejects, or fails to pay to **Melissa Earls, LPC**.
- I understand that there is a returned check fee of $35.00 and that if a returned check is not cleared up in 30 days Melissa Earls LPC will file a suit with the Fort Bend County District Attorney's Office.
- I understand that all co-pays are due at the time of service.
- I understand that if I do not give at least 24 hours notice in canceling an appointment I will be charged a fee of $40.00 that must be paid at my next scheduled appointment.
- I understand that the rate for an initial session is $125.00 and for subsequent sessions is set based on the scheduled session as posted in the Client Information Binder in the Lobby. These fees are for 30, 45 or 60 minute sessions.
- I understand that although **Melissa Earls, LPC** has earned a Doctorate in Education in the Field of Counseling, she is not a psychiatrist and as such can not recommend or prescribe medications but can encourage clients to see an M.D. for a medication evaluation.
- I acknowledge that I have received and understand the Notice of Privacy Practices for this office:
- I hereby permit **Melissa Earls LPC** to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.
- **You have the right to request that this office restrict uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.**
- Please see our Notice of Privacy Practices for more complete description. You will find this Notice of Privacy Practices in a notebook in our office. This Notice of Privacy Practices is also provided to you in your intake packet. If this consent is revised in the future, you may obtain a revised copy from this office.

By signing below I confirm that I have read agree to and received the above information:

_____ _____

Client/Parent of Client *Date Received and Read*

(Parent or Guardian if Patient is a Minor)

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to:

1. Facilitate payment by third parties for services rendered by us.
2. Or, to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes purposes.

Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You, the patient, may revoke the authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by it's terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Department of Health and Human Services.

You may speak with the office manager to obtain additional information regarding any questions you may have concerning this Notice, or to receive a printed copy of the Notice. The Notice of Privacy Practices is effective as of April 14, 2003