DATA SHEET

DATE: _____ SS# _____

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ AGE: _____

_____ SEX: _____

TELEPHONE: _____RELIGIOUS PREFERENCE_____

(WORK)_____ (CELL) _____

EDUCATION: _____REFERRAL SOURCE: _____

EMPLOYER: _____ FAMILY PHYSICIAN: _____

NEXT OF KIN: _____ TELEPHONE: _____

ADDRESS_____ RELATIONSHIP: _____

PHYSICAL PROBLEMS: _____

_____

MEDICATIONS YOU ARE PRESENTLY TAKING:_____

_____

ALLERGIES EFFECTS: _____

_____

PLEASE GIVE A BRIEF DESCRIPTION OF WHY YOU ARE HERE: _____

_____

_____

_____

Counseling Center of East Texas
Debra K. Burton, Ph.D., LPC-S, LMFT
Licensed Professional Counselor-Supervisor
Licensed Marriage and Family Therapist
P.O. Box 154437 Lufkin, Texas 75915-4437
(936) 639-3233 office (936) 639-3680 fax

Informed Consent for Counseling Services

Education: Masters in Psychology at Stephen F. Austin State University
PhD in Professional Counseling at Liberty University

Experience: I am an independent mental health practitioner trained in individual, marriage, family, and group counseling. I have been in private practice since 1982. I have been trained in all major counseling theories and I utilize an integrative approach in the counseling process. My primary therapeutic approach is based on a biophysical, cognitive-behavioral perspective. I specialize in the area of grief and trauma and I work primarily with teens and adults of all ages. I am also trained to provide couple counseling. I am a trained parenting facilitator and provide those services through a court order.

Practice: My goal is to assist individuals, couples, families and groups to achieve social, personal, career, emotional and spiritual development through the application of counseling principles and methods in order to promote and enhance a productive and healthy lifestyle. Although I am a Christian, I am respectful of the values and beliefs of others. An initial evaluation will help determine the areas that will need to be addressed during the counseling process. I will review the results of the initial evaluation with the client and present a tentative treatment plan. The Client will have ample opportunity to modify treatment goals. The counseling relationship is collaborative where the counselor facilitates change. You may stop therapy at any time or request a referral.

Appointments: Clients are seen in my office by appointment only. Payment is due when services are rendered. **A 24-hour notice is required for a cancellation or re-scheduling any appointment. A $60.00 fee will be charged for missed appointments or if sufficient notice is not given. This must be paid prior to scheduling another appointment.** We utilize a scheduling program that will send you a text message at the time an appointment is scheduled and will send you a reminder text 48 hours before your scheduled appointment. If you need to change an appointment, please call our office number at 936-639-3233, to reschedule your appointment.

Fee Schedule:

Initial Office Visit (new client)-1 hour.....$200.00
Regular Office Visit (established client)-1 hour.....$150.00
Regular Office Visit (established client)-45 minutes.....$115.00
Court-Related Office Visit (new client)-1 hour.....$300.00

Court-Related Office Visit (established client)-1 hour.....$250.00
Court Testimony – per hour.....$350.00
(Minimum 3 hours, paid in advance $1050.00)
Court Preparation (per hour).....$125.00
Assessments .....$25.00-$150.00

Consultation Report.....$35-$50
Written Evaluation/Narrative Report (per hour) $125
Attention-Deficit/Hyperactivity Disorder Evaluation..... $450

Other Costs:
Time spent in any administrative services including correspondence to or consultation with attorneys, physicians, or other mental health professionals, and any requested reports will be billed at the standard fee ($100 per hour) with a 15 minute minimum charge. THESE FEES CANNOT BE FILED ON INSURANCE AND WILL HAVE TO BE PAID AT THE TIME OF SERVICE.

Confidentiality: Confidentiality is guaranteed except in cases of threat of imminent harm to self or others. Confidentiality is limited in the event of reported sexual or other abuse to minors, disabled persons, or the elderly, and where there is a specific judicial order for the release of records or information.

Insurance: I am a covered provider on many different insurance plans and will continue to provide assistance with filing claims and precertification information. **It is, however, your responsibility to provide your current insurance information to me prior to your visit.** Some plans require the insured to contact them initially before they will pre-certify your visits, and if you are in doubt, please ask for assistance. **Please do not assume that because you have insurance, it will automatically pay for your visits.** There is co-pay, coinsurance, and deductible information that must be verified. If I do not have your insurance information on file prior to your visit, you will be responsible to pay the full amount when services are rendered.

Marriage/Couple Counseling is a fee paid service and will not be filed on insurance. Again, I will gladly assist you in trying to determine your benefits, but this must be done prior to your visit.

After-hour Emergencies
If it is after hours, please go to your local emergency room for an evaluation.

Therapist's Incapacity or Death
In the event I become incapacitated or die, it will become necessary for another therapist to take possession of your records. By signing the Informed Consent, you give your consent for another therapist at our office to take possession of your files and records and provide you with copies upon request, or to deliver them to a therapist of your choice.

I HAVE READ THE OFFICE POLICY AND INSURANCE INFORMATION ABOVE AND UNDERSTAND ITS CONTENTS.

Signature: _____

Date: _____

Complaints or request for information should be addressed to:

Texas State Board of Licensed Professional Counselors
P.O. Box 12197
Austin, Texas78711
(512) 834-6658
http://www.tdh.state.tx.us/hcqs/plc/lpc/lpc def.htm

Approved Supervisor by the Texas State Board of Examiners for Professional Counselors

Texas State Board of Examiners of Marriage and Family Therapists
P.O. Box 149347
Austin, Texas 78714-9347
(512) 834-6657
FAX (512) 834-6677
mft@dshs.state.tx.us

Counseling Center of East Texas
Debra K. Burton, Ph.D., LPC-S, LMFT
Licensed Professional Counselor-Supervisor
Licensed Marriage and Family Therapist
P.O. Box 154437 Lufkin, Texas 75915-4437
(936) 639-3233 office (936) 639-3680 fax

Cancellation/No-Show Policy

Your appointment time is reserved especially for you. If you will be unable to keep your appointment, please call to cancel your appointment at least 24 hours prior to your scheduled appointment. This allows Dr. Burton to offer that time to another client. ***Effective April 1, 2022, if a client forgets or fails to show up for their appointment, there will be a $60.00 rescheduling fee charged to their account that will be due at the time of the next scheduled appointment. This same policy applies to appointments canceled with less than 24 hours' notice.*** We make every effort to text and confirm your appointment in advance. However, due to our heavy caseload we cannot guarantee that you will receive a confirmation text. We strongly recommend that you write your appointment time on your calendar and put a reminder on your cell phone that will notify you a day before your scheduled appointment.

Thank you for your consideration regarding this important matter.

_____

Client Signature (Client's, parent/Guardian if under 18)

_____

Date

REGISTRATION

(PLEASE PRINT)

Debra K. Burton, Ph.D., L.P.C., L.M.F.T.
600 S. John Redditt Dr. * Lufkin, Texas 75904
P.O. Box 154437 * Lufkin, Texas 75915
(936) 639-3233 * (936) 639-3680 fax

Date_____ Home Phone_____

PATIENT INFORMATION

Name_____ Soc. Sec. #_____
Last Name First Name Initial

Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____ Phone_____

PRIMARY INSURANCE

Person Responsible for Account_____
Last Name First Name Initial

Relation to Patient_____ Birthdate_____ Soc. Sec. #_____

Address (If different from patient's)_____ Phone_____

City_____ State_____ Zip_____

Person Responsible Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____ Relation to Patient_____ Birthdate_____

Address (If different from patient's)_____ Phone_____

City_____ State_____ Zip_____

Subscriber Employed by_____ Business Phone_____

Insurance Company_____ Soc. Sec. #_____

Contract #_____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

* Copy of INS. CARD - front & back

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

FOR PRIVATE PRACTICE OF: Debra K. Burton, PhD, LPC, LMFT

This form is an agreement between you, _____

and me, **Dr. Debra Burton.** When I use the word "you" below, it will mean you or your child, relative, or other person if you have written his or her name

here _____.

When I examine, diagnose, treat, or refer you, I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information here to decide what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let me use your information here and send to others (with prior consent). The Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in my Notice of Privacy Practices, I cannot treat you.

In the future I may change how I use and share your information and so may change our Notice of Privacy Practices. If I do change it, you can get a copy by calling me at 936-639-3233, or from my privacy officer.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or personal representative Date

_____ _____

Printed name of client or personal representative Relationship to client

Date of NPP _____ **Copy given to client/parent/pers. repr. Witness initials/date** _____

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

Debra K. Burton, PhD, LPC, LMFT
Licensed Professional Counselor
Licensed Marriage and Family Therapist
600 S. John Redditt Drive Lufkin, Texas 75904
PO Box 154437
936-639-3233 Fax: 936-639-3680

Authorization for Treatment

I authorize Debra Burton, PhD, LPC, LMFT to provide outpatient therapy services to me, _____, or my child, _____.

I understand that this authorization is subject to revocation at any time, except to the extent that action has been taken in reliance thereon. In any case, this consent will expire upon termination of services with Debra Burton, PhD, LPC, LMFT.

I HAVE READ THE AUTHORIZATION FOR TREATMENT ABOVE AND UNDERSTAND ITS CONTENTS.

Signature_____

Date_____

Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Personal Information

Name: _____ Date: _____
Parent/Legal Guardian (if under 18): _____
Address: _____
Home Phone: _____ May we leave a message? □ Yes □ No
Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No
Email: _____ May we leave a message? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*
DOB: _____ Age: _____ Gender: _____
Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Referred By (if any): _____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No
If yes, please list:

_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list and provide dates:

_____
_____

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

_____

2. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

3. How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems: _____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

_____

11. What significant life changes or stressful events have you experienced recently? _____

_____

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	
Anxiety	yes / no	
Depression	yes / no	
Domestic Violence	yes / no	
Eating Disorders	yes / no	
Obesity	yes / no	
Obsessive Compulsive Behavior	yes / no	
Schizophrenia	yes / no	
Suicide Attempts	yes / no	

Additional Information

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work? _____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____

3. What do you consider to be some of your strengths? _____

4. What do you consider to be some of your weaknesses? _____

5. What would you like to accomplish out of your time in therapy? _____

What is your reason for seeking help now? _____

Are any of the following conditions a problem to the client at this time? *(Check the ones that apply)*

☐ Thoughts of suicide	☐ Problems with sleep	☐ Sexual problems
☐ Plans to harm self	☐ Anxiety	☐ Sexual orientation
☐ Thoughts of harming someone else	☐ Panic Attacks	☐ Gender identity issues
☐ Plans to harm someone else	☐ Chronic fear	☐ Relationship to parents
☐ Self-injury	☐ Irrational fears	☐ Relationship to children
☐ Depression	☐ Problems due to abuse or trauma	☐ Conflicts at work
☐ Grief	☐ Obsessions/compulsions	☐ Problems in school
☐ Stress	☐ Behavioral problems	☐ Loss of faith in God
☐ Loneliness	☐ ADHD	☐ Religious doubts
☐ Guilt feelings	☐ Anger	☐ Substance abuse
☐ Loss of hope	☐ Rage	☐ Other? Explain:
☐ Loss of meaning in life	☐ Problems with relationship partner	

Medical History of Client

Primary Physician: _____ Date of last medical examination? _____

List any physical illness or symptoms the client is having at this time: _____

_____

List major surgeries or illnesses in the last five years: _____

_____

List current medications: _____

_____

Physician prescribing medications for mental health issues: _____

Communications Policy

Contacting Me

When you need to contact Dr. Debra Burton for any reason, these are the most effective ways to get in touch in a reasonable amount of time:

- By phone (936-639-3233, ext. 203) You may leave messages on the voicemail, which is confidential.
- If you wish to communicate with me by normal email or normal text message, please inquire about the potential confidentiality risks of doing so.
  OR
- If you wish to communicate with me by normal email or normal text message, please read and complete the Consent for Non-Secure Communications form included with these office policies.

If you need to send a file such as a PDF or other digital document, ***"please print and FAX it to 936-639-3680 or preferably print and bring it to the office and give it to me or our office manager."***

Please refrain from making contact with me using social media messaging systems such as Facebook Messenger or Twitter. These methods have very poor security and I am not prepared to watch them closely for important messages from clients.

It is important that we be able to communicate and also keep the confidential space that is vital to therapy. Please speak with me about any concerns you have regarding my preferred communication methods.

Response Time

I may not be able to respond to your messages and calls immediately. For voicemails and other messages, you can expect a response within the next business day, unless I am out of town (weekends are exempted from this timeframe.) I may occasionally reply more quickly than that or on weekends, but please be aware that this will not always be possible.

Be aware that there may be times when I am unable to receive or respond to messages, such as when out of cellular range or out of town.

Emergency Contact

If you are ever experiencing an emergency, including a mental health crisis, please go to your local emergency room.

If you need to contact me about an emergency, the best method is:

- By phone (936-639-3233)
- If you cannot reach me by phone, please leave a voicemail on ext. 203

Please note that SMS (normal phone text messages) are not designed for emergency contact. SMS text messages occasionally get delayed and on rare occasions may be lost.

So, please refrain from using SMS as your sole method of communicating with me in emergencies.

Disclosure Regarding Third-Party Access to Communications

Please know that if we use electronic communications methods, such as email, texting, online video, and possibly others, there are various technicians and administrators who maintain these services and may have access to the content of those communications. In some cases, these accesses are more likely than in others.

Of special consideration are work email addresses. If you use your work email to communicate with me, your employer may access our email communications. There may be similar issues involved in school email or other email accounts associated with organizations that you are affiliated with. Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages, we exchange with each other.

REQUEST FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I _____ AUTHORIZE: _____

name of client

name of counselor

For myself or the following minor child or children:

600 S. John Redditt
Lufkin, Texas 75904

_____

(name of minor child or children)

TO TRANSMIT TO ME BY NON-SECURE MEDIA THE FOLLOWING TYPES OF PROTECTED HEALTH INFORMATION RELATED TO ME OR TO MY MINOR CHILDREN'S HEALTH RECORDS AND HEALTH CARE TREATMENT:

_____ Information related to the scheduling of meetings or other appointments

_____ Information related to billing and payment (but not to include any financial or claims-related identifiers including, but not limited to credit card numbers, insurance plan numbers, diagnosis codes, or procedure codes).

_____Any health information that you are comfortable sending by non-secure media on yourself or minor children. My only response to your email or text will be letting you know that I have received your information or concur with scheduling changes. If I need to respond, I will call you and discuss information over the phone.

TERMINATION:

_____ This authorization will terminate when you have been discharged from service.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I have been informed that a secure means to communicate with my counselor is by fax, drop-off, or voicemail. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

_____ _____

Signature of client Date

_____ _____

Signature of counselor Date

Debra K. Burton, PhD, LPC, LMFT
Licensed Professional Counselor
Licensed Marriage and Family Therapist

Informed Consent for Tele-Counseling services

Due to the Emergency rule for telehealth services adopted on March 17th, to reduce barriers for accessing services as a result of Corona Virus pandemic, I am offering counseling sessions through tele-counseling services. Tele-counseling services include using the telephone or interactive tele-video conferencing technologies for individual, marriage, and family counseling.

I have a HIPAA compliant platform, SecureVideo, that uses ZOOM Cloud Meetings on Smartphones and Zoom Videoconferencing on computers. ZOOM is a free service. I will send a text or email that will contain a link for your scheduled appointment. I will also email instructions on how to use the SecureVideo.

During the COVID-19 Nationwide Public Health Emergency, the Office for Civil Rights (OCR) at the US Department of Health and Human Services (HHS), is allowing counselors to serve clients through everyday communications technologies. This means I can use widely available communications apps, such as FaceTime, Skype, Google Meeting, and Zoom.

I will contact you before your first session and give you an option for your tele-counseling services, including counseling by phone. You will want to choose a location that will protect your privacy with minimal distractions.

There are Benefits with Tele-Counseling:

- Ability to receive Counseling at times or in places where this service may not otherwise be available
- Ability to receive Counseling services when you are unable to travel to the office and attend a face-to-face session
- Ability to have Counseling sessions in a manner that is more convenient and easier to manage.

There are a few possible issues that can occur with Tele-Counseling: Internet connections and cloud services can have problems and interfere with communication (*if a session is experiencing signal problems, we can communicate by phone for the remainder of the session if needed*). Non-HIPAA

compliant services may not have the level of protection that a HIPAA compliant service has, to protect your private information that is being transmitted. Computer or smartphone hardware can have sudden failures or run out of power, or local power services can go out.

You have the right to stop receiving mental health services through tele-counseling at any time.

_____gave verbal and/or written permission to receive tele-counseling services on_____.

We have reviewed and discussed these items:

_____ _____

Signature of client(s) Date

_____ _____

Signature of client(s) Date