Nancy Stroud L.C.SW, RRT

Psychotherapist

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INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provided here is protected as confidential information.

Name: _____
(Last) (First) (M.I.)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (M.I.)

Birth Date: / / Age:_____ Gender: Male □ Female □

Marital Status:

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

Name: _____
(Last) (First) (M.I.)

Please list any children/age: _____

Address: _____

_____
(City) (State) (Zip)

Home Phone: ( ) _____
May we leave a message? Yes □ No □

Cell/Other Phone ( ) _____
May we leave a message? Yes □ No □

Email Address: _____
May we email you? Yes □ No □

Referred by (if any): _____

Have you previously received any type of psychotherapy, psychiatric, services, etc.? Yes □ No □

How helpful was this previous experience? _____
_____
_____
_____

Are you currently taking any prescription medication(s)? Yes □ No □

Please list medication(s): _____
_____

Have you ever been prescribed psychiatric medication? Yes □ No □

How did these psychiatric medication(s) affect you? _____
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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

   Very good Good Satisfactory Unsatisfactory Poor

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

_____
_____

3. How would you rate your current sleeping habits? (please circle)

   Very good Good Satisfactory Unsatisfactory Poor

4. Please list any specific sleep problems you are currently experiencing: _____

_____
_____

5. How many times per week do you generally exercise? _____
6. What types of exercise do you participate in? _____
7. Please list any difficulties you are experiencing with your appetite or eating patterns:
   _____
   _____
   _____

_____

8. Are you currently experiencing overwhelming sadness, grief, or depression? Yes □ No □ If yes, for approximately how long? _____

9. Are you currently experiencing: anxiety, panic attacks, chronic pain or have any phobias? Yes □ No □ If yes, when did you begin experiencing this?

10. Do you or your family members have any history of alcohol or drug abuse? Yes □ No □

11. Are you currently in a committed, long term relationship? Yes □ No □ If yes, for how long?

12. On a scale of 1-10, how would you rate your relationship? _____

13. Have you or your family recently experienced any significant life changes? _____
    _____
    _____
    _____
    _____

FAMILY MENTAL HEALTH HISTORY:

In the section below, please circle if you or anyone in your family has dealt with any of the following. Please Circle and clarify who it has affected. Please clarify who it has affected.

14. Alcohol/Substance Abuse yes/no
15. Anxiety yes/no
16. Depression yes/no
17. Domestic Violence yes/no
18. Eating Disorders yes/no
19. Obesity yes/no
20. Obsessive Compulsive Behavior yes/no
21. Schizophrenia yes/no
22. Suicide Attempts yes/no

ADDITIONAL INFORMATION:

23. How much time have you lost from work or school due to current difficulties?
    _____
    _____
    _____
    _____

24. What is your current employment situation? _____
    _____

_____

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

26. Do you consider yourself to be spiritual or religious? Yes □ No □ If yes, describe your faith or belief:_____

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

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

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

INFORMED CONSENT AND AUTHORIZATION FOR PSYCHOTHERAPY

Psychotherapy is often utilized to help people with life challenges. There are many ways to "do" therapy. Nancy Stroud utilizes several therapeutic methods applied based on the need of each individual client which will be discussed.

Should you choose to proceed with treatment, the goal for a positive outcome becomes our mutual responsibility. This begins with your commitment and trust in the treatment process and my commitment to address your concerns and/or questions as they arise during session. This agreement also involves my commitment to you as your therapist, helping guide you in a discovery process of your desired treatment goals.

In addition to being a clinical process, therapy involves a professional arrangement, regulated by laws, ethics, your rights as a client, and my standard business practices.
Before therapy can begin, however, your agreement to the business practices described herein is required, by initials at specified places and your signature.

If you are presently meeting with another therapist, please inform us.

PAYMENT OF FEES

Paying for therapy is often a very sensitive topic. We can discuss your concerns about payment as needed. However, Texas law requires that all fee(s) are established and agreed to before we can begin. This section clarifies all fees, and defines your financial responsibilities.

The fees are as follows, payable each session and beginning at your first appointment:

50 Minutes individual therapy $130.00
50 Minutes couple counseling $140.00
4 Hours of Rapid Resolution therapy $350.00
Eating Disorders assessment $160.00

A $25.00 returned-check fee will be assessed.

1. Canceling or rescheduling appointments requires a (24) hour notice by telephone to avoid having to pay the entire fee for a missed session (No e-mails please.).

2. Telephone conversations between us, for any reason, in excess of (15) minutes per day may be billed proportional to your hourly fee.

Please initial here: _____

LEGAL / COURT (all services)

Any and all time spent by the provider in relation to any legal issue, including disability claims, notarizing, paperwork for claims, signing any type of document, is at a rate of $2,500 for the first 4-hour block or any part thereof. Every subsequent hour or part thereof, in the same day is at a rate of $325. Each additional day begins this fee cycle again: $2,500 for the first 4-hour block or any part thereof and every subsequent hour beyond the initial four, or part thereof, in the same day, at a rate of $325. This begins at the time provider leaves office and continues until the time they return. By signing this agreement, you agree to be solely and fully responsible for all payments due, should the clinician or any other member of this office, be required or requested to be involved in any legal proceeding; including but not limited to mediation, court/trial, depositions, phone conferences, meetings and consultative services. You are still responsible for these, under contractual law, even if the provider is summoned under a subpoena. This payment must be made, in full, on each day the provider spends such time in relation to any legal issue.

Please initial here: _____

CONFIDENTIALITY LIMITS AND EXCEPTIONS

1. Normally, everything we discuss will be held confidential. Unless you provide a signed authorization, I will not speak to or correspond with anyone about you.

2. Texas law and professional ethics either mandate or permit therapists to break client confidentiality under certain circumstances. Some exceptions to confidentiality include situations in which there is reasonable suspicion that any of the following has ever occurred or is occurring now:

   •you or your child presents a danger to self for others

   •a child or dependent adult is the victim of emotional, sexual or physical abuse, neglect or unjustified mental suffering

   •a dependent adult or any person over the age of 65 years is the victim of physical abuse, emotional abuse, abandonment, forced isolation, fiduciary abuse, or neglect

   Note: the preceding is a sample, and not a complete list of exceptions to confidentiality.

Your initials here indicates agreement to the 'Confidentiality Limits & Exceptions': _____

MEDICAL, PSYCHIATRIC and PSYCHOLOGICAL EVALUATIONS

If medical, psychiatric and/or psychological evaluation seems warranted, we will discuss the nature of these evaluations and appropriate referrals will be provided. If the need for evaluation(s) by other professionals is established and you do not follow these recommendations, your therapy may necessarily be suspended or terminated.

LIMITS OF COMMUNICATION

1. Every effort will be made to assist you, especially during crisis. However, there may be times when contacting you won't be possible. Therefore you must agree to first call 911 or go to the nearest hospital Emergency Room for assistance, any time you suspect you are in crisis.

2. As a standard business practice, each appointment ends 50 minutes from the scheduled start of the appointment, regardless of your arrival time. I am not able to extend sessions since appointments begin on the hour.

3. Calls are retrieved from my voice mail at (281) 693-1455 several times during the day (M-F) at random intervals.

4. If necessary, my voice-mail will provide the name and telephone number of a colleague

who you can call for assistance when I am not available.

Your initials here indicates agreement to the 'Limits of Communications': _____

TREATMENT TERMINATION

1. Ideally, therapy ends when we agree your treatment goals have been achieved.

2. You have the right to stop treatment at any time. If you make this choice, referrals to other therapists can be provided.

3. Professional ethics mandate that treatment continues only if it is reasonably clear you are receiving benefit. Other legal or ethical circumstances may arise and compel me to terminate treatment. In these cases appropriate referral(s) will be offered.

4. Other situations that warrant terminate include: regularly becoming enraged or threatening during session; bringing a weapon onto the premises; persistent drug abuse; arriving under the influence of drugs or alcohol; disclosing illegal intentions or actions.

Your initials here indicates agreement to the 'Treatment Termination' conditions: _____

RISKS ASSOCIATED with PSYCHOTHERAPY

Like many things in life, psychotherapy has inherent risks. Some of these risks to you are:

1. Disruptions in your daily life that can occur because of therapeutic changes

2. Emotional pain due to exploring personal issues and family history

3. Experiencing emotional pain within your current relationships

4. Although therapy begins with the hope that your life and relationship(s) improve, there Is no guarantee that this will occur

Your initials here indicates agreement to the 'Risks Associated with Psychotherapy': _____

OFFICE ENVIRONMENT

Please be advised that if you leave your family members or unsupervised minors you will be responsible for their behavior and actions while you are on the premises.
This includes both the office and the building.

AUTHORIZATION TO COMMENCE PSYCHOTHERAPY

1. Your signature below will verify that you have read (or that I have read to you) the information in this authorization and you were given the opportunity to ask questions about

anything you did not understand up to this point. By signing, you freely acknowledge your willingness to undergo treatment using psychotherapy methods offered by Nancy Stroud, L.C.S.W. and in accordance with this 'Informed Consent.'

2. You also agree to enter into a professional business arrangement according to all business practices outlined in this agreement. You accept total financial responsibility for payment of all fees and services as described, regardless of insurance coverage or any other 'third-party' payers.

3. You will also be releasing me of liability that directly or indirectly results from disclosure or exchange of any information covered in this agreement. At your request, a copy of this and any other document in your record that bears your signature will be provided.

FINANCIAL AND OFFICE POLICIES

OFFICE POLICIES:

Failure to keep your scheduled appointments with Nancy Stroud, L.C.S.W. hinders her ability to provide the best care to clients.

We ask that you show consideration by calling at least 24 hours prior to your appointment if you are unable to attend. Please call (281-693-1455) with your notification. This will allow the opportunity to offer that appointment to another client.
Repeated late cancellations or no-shows are disruptive to the optimal delivery of care to you and my other clients. Missed appointments prevent other clients from coming in at the same time and affect the consistency of your own treatment program. As a result, 3 late cancellations or no shows will result in discontinuing therapy with Nancy Stroud, L.C.S.W.

Failure to give the 24 hour notice necessary prior to cancellation will result in a "No-Show Appointment Fee."

THE NO-SHOW APPOINTMENT FEE is $100.00.

Please provide valid credit card information in the space below. You will only be charged if you do not provide appropriate notice for your cancellation. You will be notified prior to being charged. You may dispute charges in writing to Nancy Stroud, L.C.S.W. Nancy Stroud, L.C.S.W. reserves the right to waive fee or honor charges at her discretion.

Client Signature
_____

Current Date _____

Client Signature
_____

Current Date _____

YOU ARE EXPECTED TO PAY AT TIME OF VISIT.

I understand my financial obligations to treatment received from Nancy Stroud, LCSW as stated above, and agree to pay for any and all services received. I understand that my credit card will be charged.

Name as it appears on the Credit Card:
_____

Credit Card Type: Visa MC AMEX Other

Credit Card #: _____
Exp. Date: _____

I understand Nancy Stroud, L.C.S.W.'s appointment cancellation policy and understand my responsibility to plan appointments accordingly and notify Nancy Stroud, L.C.S.W. appropriately if I have difficulty fulfilling my scheduled appointments.

Client Signature/Guardian Signature
_____

Current Date _____

Witness Signature
_____

Current Date _____