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512-827-1460

Elizabeth Jenkins, PhD, LMFT
Licensed Marriage and Family Therapist
Certified Life Coach

NEW CLIENT INFORMATION

General Information

First Name:_________________________MI: _____ Last Name: _______________________________

Address:____________________________City: ________________State: ______________ Zip_______

Home Phone: _____________________________________ Leave Msg: ____YES ___NO
Cell Phone: _____________________________________ Leave Msg: ____YES ___NO

Email Address: ____

Date of Birth: _____________ Gender: Male______Female_____

Emergency Contact: ____________________________Phone: _____________ Relationship _________

Insurance Information
Insurance Carrier (Aetna, BCBS, UBH, etc.,) ____________ Mental Health Carrier________________
Mental Health/Behavioral Health Provider Phone Number: ___________________________________

ID#: ______________________________ Group Number: ______________________________________

Client relationship to Subscriber: ____
Subscriber Name: _____________________________Subscriber DOB: ___________________________
Subscriber SSN #: ___________________Subscriber Address: _________________________________
Subscriber's City, States, Zip: ____
Subscriber's Phone No.: ____

EAP: ____YES ____NO

EAP Carrier: _________________________________ Phone No. ________________________________

Others In Household
Name: ____DOB: _______ Relationship: _____________

Name: ____DOB: _______ Relationship: _____________

Name: ____DOB: _______ Relationship: _____________

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Treatment Agreement

All counseling sessions are confidential. No information can be released without your written consent except in cases of suspected child or elder abuse, potential danger to self and/or others, intentionally exposing another to AIDS or the HIV Virus, or court subpoena. In such instances, I understand that it is my therapist legal obligation to protect others and me. I understand that my counselor must abide by the mandatory reporting laws stated in the Texas Family Code (Chapter 261) and that I may have the counselor explain this further should the need arise.

Full payment for each session is expected at the time of services rendered. The standard fee for the office is $150.00 per hour, unless other arrangements have been made. Sessions will be rescheduled at the client's expense should payment arrangements not be made prior to the session.

For out of office consultation such as a hospital session(s), legal consultations, and school conferences, the charge is $900.00 per hour with a minimum 4 hours. No additional fees for travel time, mileage, or parking fees are charged, unless travel is required outside of Travis or Williamson County

Counseling sessions will begin at the specified time and will last between 45 minutes unless other arrangements have been made. This time frame is firm even though important issues may sometimes be interrupted. This is necessary to allow you and others to adhere to their daily schedules without unnecessary delays. If you are late for the appointment, the session will still end the specified time. If you are more than 15 minutes late to a session, this will be considered a late cancellation, unless prior arrangements have been made with the therapist.

Your session time is reserved for you. Twenty-four business hours (24 hrs.) notice is required for cancellation without charge. Appointments for Monday must be cancelled on the preceding Friday. If you fail to give this required cancellation notice, you will be charged for the missed session. You will be charged for the sessions missed with no cancellation given. We thank you in advance for honoring our 24-business hour cancellation policy. We ask that if you need to cancel your appointment, you call as early as possible. Each day clients in crisis, and sometimes in emergencies, try to get into our open slots. We know that one day you may be the patient requesting an additional appointment, so we ask that all patients respect one another and their scheduled appointment. Two cancellations without 24-hour notice or two missed sessions without cancellation will necessitate your termination of services with Dr. Elizabeth Jenkins, LMFT and referral back to original source of referral. The price of your missed session is the same as your total regular fee. You have given consent to have a form of payment stored in the office's encrypted client portal. This form of payment will be used to process your No Show/Late Cancellation at the time of your scheduled appointment. Third-party payment plans will not be billed for session no-shows or late cancellations and thus are expected from the client (except Medicaid). Please notify the therapist as soon as possible when you become aware that you will miss a session or as soon as possible after a session without cancellation notice so your therapist will know you remain interested in the continuing therapy. Therapy sessions can be terminated if the client does not contact the therapist within seven days of not showing up for an appointment with any notice of cancellation.
There is a $35.00 service charge for returned checks. The check will be turned over to the District Attorney's Office should you fail to pay for the returned check within 30 days. Once there has been a returned check, all fees must be paid in the form of cash, money order, or cashier's check. No further appointment will be scheduled until the returned check has been paid.

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Dr. Elizabeth Jenkins, LMFT may report past due accounts to collection agency should all other attempts to recover that past due balance be exhausted. Such reports may negatively influence your credit history. Client wishing to file claims with their insurance company to cover the cost of the sessions (or a portion of the cost) will need to make arrangements with the therapist as to whether or not sessions will be covered and who will submit claims. Dr. Elizabeth Jenkins, LMFT will only submit claims to the Primary insurance company for bill insurance. Clients will be responsible for filing claims with their secondary insurance company if they so choose.

There may be occasions where you need to speak with your therapist and your therapist is not available. In this event you may call Bluebonnet Trails Emergency After Hours Number at (1-800-841-1255). If you need immediate psychiatric services, you may call Hotline to Help (472-4357), Psychiatric Emergency Services (454-3521), or visit your local Emergency Room if your needs are urgent in nature.

There may be occasions during some family therapy sessions to see either particular child/children or the parents without the children. Arrangements should be made for someone to watch the children in the waiting room, as the counselor does not assume responsibility for unattended children and assure the respectful treatment of others in the office/waiting room area.

As part of ongoing training and supervision, client sessions may be video or audio recorded with their written consent. These recordings will only be used for purposes of training with an approved clinical supervisor.

There are certain risks associated with therapeutic process that should be understood before real change progresses. Some of the more common risks you should be aware of are;

Long-lasting change often requires s significant investment of time, often longer than clients expect initially.

Clients may experience an increase in symptoms and a corresponding decrease in emotional and psychological stability at different times during the therapeutic process. This is most likely to occur in early stages of therapy, but may occur at any point, usually due to new awareness of previously unconscious, emotionally laden material.

Relationships are often affected as a result of therapy. Significant relationships will often experience various degrees of tension as a client progresses and changes. This is most common in close family relationships, but may extend beyond to your social and professional life.

As a client, you may choose to end therapy anytime. However, if you choose to terminate your therapy, it is requested that you attend a termination session for closure purposes. You also have the right to refuse or negotiate modification of any treatment technique. The possible positive or negative effects of entering or not entering counseling and/or using or not using certain techniques may be discussed at any time during your therapy sessions. All services will be rendered in a professional manner consistent with accepted ethical standards. It is impossible to predict the length of treatment or guarantee any specific results regarding therapy. However, working with your therapist, being responsible in your attendance, setting realistic goals, and being committed to improve/grow will most likely result in your achieving the possible outcome(s).

If at any time you are dissatisfied with your progress in counseling or with your therapist, please address this with your therapist. If your dissatisfaction continues, your therapist will provide you with at least three possible referral sources. Should you feel the need to file a complaint with the Texas State Board of Examiners of Licensed Marriage & Family Therapy, you may call (1-800-942-5540, or submit in writing to: Licensed Marriage & Family Board, 1100 W. 49th Street, Austin, TX. 78756-3183

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In case of Emergency please contact: ____
Relationship to client: ____
Daytime/Evening Phone Number: ____

My signature below implies that the proceeding policies have been discussed with me and I am in agreement with them.

My signature further implies I will be financially responsible for payment for services rendered (or the cost of sessions not covered if submitted to third-party payment plan except Medicaid). If two people will be writing checks, both must provide the following information.

1st Responsible Party

Therapist Signature_____________________________

Signature___________________
Date of Birth________________
Date ______________________

2nd Responsible Party

Signature___________________
Date of Birth________________
Date ______________________

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Health Insurance Portability and Accountability Act (HIPAA) Notice

This notice describes how psychotherapy and medical information about you may be used and disclosed and how you can get access to the information. Please review it carefully. This information is required under the Health Insurance Portability and Accountability Act (HIPAA) passed by Congress in 1996.

Uses and Disclosures for Treatment, Payment and Health Care Operations.

- Your protected health information (PHI) may be used and/or disclosed for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions.
- PHI refers to information in your health record that could identify you.

Treatment, Payment, and Health Care Operations:

- Treatment is when your health care and other services related to your health care are provided or managed. An example of this is consultation with another health care provider, such as your family physician or another mental health professional.
- Payment is being reimbursed for your health care. Examples of payments are when your PHI is disclosed to your health insurance to obtain reimbursement for your health care or to determine eligibility or coverage. • Health Care Operations are activities that related to the performance and operation of this practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.
- Use applies only to activities with the office, clinic, practice group, etc., such as sharing employing, applying, utilizing, and examining information that identifies you.
- Disclosure applies to activities outside the office, clinic, practice group, etc., such as sending, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

• PHI may be used or disclosed for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An authorization is written permission above and beyond course that permits only specific disclosures. In those instances when asked for information for purposes outside of treatment, payment, and health care operations, authorization will be obtained from you before releasing information. Authorization will also need to be obtained before releasing your psychotherapy notes. Psychotherapy notes are notes created during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

HIPAA Notice

You may revoke all authorizations of PHI or psychotherapy notes any time, provided each revocation Is in writing. You may not revoke an authorization to the extent that that authorization has been relied on or if the authorization was obtained as a condition of gaining insurance coverage and the law provides the insurer the right to contest this right under that policy.

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Uses and Disclosures with Neither Consent of Authorization

PHI may be used or disclosed without your consent or authorization in the following circumstances: • Child abuse: If there is cause to believe that a child has been or may be abused, neglected, or Sexually abused, a report of such must be made within 48 hours to the Texas Department of Family and Protective Services, the Texas Youth Commission, or to any local or state law enforcement agency.

- Adult and Domestic Abuse: If there is cause to believe that any elderly or disabled person is in a state of abuse, neglect, or exploitation, it must immediately be reported such to the Department of Family and Protective Services.
- Health Oversight: If a complaint is filed against treatment staff with any of the applicable State Licensing Boards they have the authority to subpoena confidential mental health information relevant to that complaint. • Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for the information about your diagnosis and treatment and the records thereof, such information is privilege under state law, and the information would not be released without written authorization from you or your personal or legally appointed representatives, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety: If it is determined that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, relevant confidential mental health information may be disclosed to medical or law enforcement personnel.
- Workers Compensation: If you file a workers compensation claim, records may be disclosed relating to your diagnosis and treatment to your employer's insurance carrier.

Patient's Rights and Psychotherapist's Duties

Patient's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of PHI about you. However, agreement to a restriction you request is not required.
- Right to Receive Confidential Communications by Alternative Means and Alternative Locations. You have the right to request and receive confidential communication of PHI by alternative means at alternative locations. For example, you may not want a family member to know that you are being seen. Upon your request, bills or other materials will be sent to another address.

HIPAA Notice

- Right to Inspect and Copy – You have the right to inspect and/or obtain a copy of you PHI and psychotherapy notes in your mental health billing record. Access to your PHI may be denied under certain circumstances, but in some cases you may have this decision reviewed. On your request, the details of the request and denial process will be discussed with you.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in your record. On your request, the details of the amendment process will be discussed with you.
- Right to Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, the details of this accounting process will be discussed with you.

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- Right to Paper Copy – You have the right to obtain a paper copy of the notice upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:

- Treatment staff is required by law to maintain privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
- Treatment Staff reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, treatment staff is required to abide by the terms currently in effect.
- If the policies and procedures are revised, you will be provided with a written copy.

Questions and Complaints

If you have questions about this notice, disagree with a decision made about access to your records, or have other concerns about your privacy rights, you may contact treatment staff.
You may send a written complaint to the Secretary of the U.S. Department of Health and Human Services. You have specific rights under the Privacy Rule. Retaliation against you for exercising your rights to file a complaint will not be made.

Effective Date of Privacy Policy - This notice will go into effect on April 14, 2003
I have received a copy of this document.

____________________________________ __________________________ Client
Signature Date

____________________________________ __________________________ Therapist
Signature Date

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COUNSELING INTAKE FORM

Name____Age_________Date__________

Full Address____

____

Home Phone_________________________Work______________________E-mail______________

Physical History(please be accurate, medical records may need to be disclosed at some point)

General Health____

Are you now under a doctor's care?________If yes, name of doctor______________________________

Reason for doctor's care____

Are you taking any medication?__________If yes, what kind?__________________________________

Reason for medication__________________________Last medical examination___________________

Have you ever been hospitalized for a physical illness?____Describe________________________________

____

Have you ever been hospitalized for a mental illness?____Describe_________________________________

____

Any recent major illnesses or surgeries?____

Any recurrent or chronic conditions?____

Do you smoke:________Do you take drugs?________If yes, what kind?___________________________

Do you drink?________How much?____

Any Previous Therapy/Counseling?______If yes, describe, when, where, how long, what for___________

____

What do you hope to achieve with therapy?____

____

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INTAKE 2 Work History

Occupation____ How long?______________________

If presently unemployed, describe the situation____

Hobbies/Avocations____

Family Systems Information

Where born______________________________How long there______________Ethnic ID____________

Parents: Father alive____________Where residing____________________Relationship_______________

Mother alive_________Where residing_________________________Relationship___________________

Marital Status________#of marriages__________________Spouse's name__________________________

Living with a partner_________How long______________Partner's Name__________________________

Children:#1 M F Age_____ #2 M F Age______ #3 M F Age______#4 M F Age_______#5 M F Age_____

Siblings: Circle your place in the family. If a sibling is deceased, put an X through the placement number.

#1 M F Age____ #2 M F Age____ #3M F Age____ #4 M F Age____ #5 M F Age____ #6 M F Age______

Family Alcoholism or Domestic Violence?________________ Sexual Addictions or Abuse?____________

Parents divorced?___________If yes, what year_____________Your age at the time__________________

If deceased, what year?_________Your age at the time__________Cause of death____________________

Any step-parents?________If yes, describe when and your relationship with them___________________

____

If reared by someone other than your birth parents, describe the situation in some detail________________

____

Tell anything else in the space below that you think would be helpful for me, as your therapist, to know.

____

INTAKE 3 Spiritual History

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Religious upbringing______________________________Present Affiliation__________________________

Is this an important part of your life________Whywhy not_______________________________________

Emotional Status

Are you currently experiencing strong emotions? ____If yes, describe_______________________________

____

Do you make decisions based on your emotions?________How well does that work for you?___________

____

Did you have what you would consider to be childhood or other traumas?_______If yes, describe________

____

Have you been treated for emotional disturbances?______If yes, when?______________________________

Have you had any thoughts of suicide____If so, when___________Do you have any thoughts now_______

Present Situation

Please state why you decided to come for counseling/therapy______________________________________

What is the nature of your situation____

____

What would you like to experience that is different from what you are experiencing now_______________

____

How long has this been a problem for you____

____

Please state what you would like to work on in therapy____

____

Consent for Release of Information

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I, ____, authorize the release of information to and from:

Dr. Elizabeth Jenkins, LMFT, CLC Office: 512-568-0343 Fax: 512-233-2969

To/From:

Names: ____

Address: ____

Phone Number: ________________________Fax Number: __________________________________

****
Client Name: ____

Client Social Security Number: ____

Client Date of Birth: ____

The consent for disclosure of client information may be revoked by written notification, but the revocations will not affect any action that has already taken in accordance with the consent. This consent for release of information, unless revoked, will expire one year from the date of signature or upon termination of services. This information may be faxed and a copy of this consent is as valid as an original.
****

Signature of Client: _______________________________________Date: _________________________

Signature of Parent/
Legal Guardian: _________________________________Relationship ________________Date: _______

Therapist's Signature: ________________________________ Date: _____________________________

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Parent/Guardian Information Pertaining to Minors
Informed Consent

Parents/Guardians
If you are seeking services for a child or adolescent, you may be required to participate in sessions periodically throughout the course of therapy. Know that it is within your rights as parents or legal guardians of minor children (under the age of 18) to request information concerning your child's progress and treatment. However, it is often harmful to the therapeutic process if I am not able to assure your child that our work will remain confidential. Therefore, I ask that you, as parents/guardians, agree not to ask specific questions of your child or me about his/her counseling experience. In turn, I agree to work collaboratively with you and your child in an effort to provide you with updates, and to share information with you in such a way as to preserve the therapeutic relationship.

Divorced and/or Separated Families
When the client is a minor child in a divorced and/or separated family, or a family where this is any type of legal custody arrangement in place, *it* is *a state licensing requirement* that you provide *me* with a copy of the part of your divorce decree/custody arrangement that pertains to custody of the minor child, and the right to consent for medical/psychological services. *I must receive the copy before I can provide services to the child.* There are no exceptions to this requirement. If there are multiple minors involved in treatment, a separate Informed Consent Form will need to be completed for each child/adolescent.

Court/Legal
I am not an expert witness and strongly prefer to not be involved in court related cases. If you feel you need a therapist who will be able to testify in court, I will be happy to assist you in finding appropriate referrals. If, however, we have begun working together and it is required that I give a deposition, case summary/affidavit, and/ or be available to testify, please be aware of the following policies.

Releasing Information
Therapy case files and progress notes will not be released without a court order.

Subpoenas (Testifying)
The Attorney who is issuing the subpoena will contact Dr. Elizabeth Jenkins, LMFT at least 2 weeks in advance of the court date and block out: 8:00 AM to 12:00 PM and/or 1:00 PM to 5:00 PM. The rate is $900 per hour with a 4-hour minimum. No additional fees for travel time, mileage, or parking fees are charged, unless travel is required outside of Travis or Williamson County. If the requirement to appear in court is issued less than two weeks' notice, the attorney or client requesting the court appearance will be billed for all appointments that need to be rescheduled at the full hourly rate for each appointment. Fees must be paid IN ADVANCE. Payment is accepted from either the attorney or the client.

Depositions
Depositions are billed at $900 per hour with a 4-hour minimum. No additional fees for travel time, mileage, or parking fees are charged, unless travel is required outside of Travis or Williamson County. If the deposition is scheduled with less than two weeks' notice, the attorney or client

requesting the deposition will be billed for all appointments that need to be rescheduled at the full hourly rate for each appointment. Fees must be paid IN ADVANCE. Payment is accepted from either the attorney or the client.

Affidavits/Summaries
Affidavits and/or case summaries are billed at a rate of $900 per hour. Fees must be paid IN ADVANCE. Payment is accepted from either the attorney or the client.

Attorney Consultation
Telephone consultation with attorneys are billed in 15-minute increments at a rate of $100 per 15 minutes. Fees must be paid IN ADVANCE. Payment is accepted from either the attorney or the client.

PARENT /GUARDIAN OF CHILD/ADOLESCENT CLIENTS

I certify that I am the:
____Father
____Mother
____Legal guardian

Of, ________________________________, the minor for which I am seeking services. I further certify that I have the legal and/or custodial authority that allows me to give informed consent for the minor, and that by signing below, I hereby give my authorization and consent for the minor to receive counseling from Dr. Elizabeth Jenkins, LMFT.

__________________________________ __________________________

Client Signature Date

__________________________________ __________________________

Therapist Signature Date

Dr. Elizabeth Jenkins, LMFT, CLC

Phone: 512-827-1460 Email: drliz@drlizjenkins.com

Informed Consent Addendum or Online/Teletherapy This form is designed to allow you to give informed consent for the use of video technology for online therapy. Read it thoroughly for your understanding and to ensure all your questions are answered before signing to give your consent.

This form is to be used in conjunction with, but does not replace, the Informed Consent document that is required of all clients prior to beginning therapy services.

1. Therapy conducted online is technical in nature and problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a third party may result in service interruptions. Any problems with internet availability or connectivity are outside the control of Dr. Liz Jenkins ("Therapist") and there is no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, Therapist will call you via telephone.

2. It is the responsibility of the client to provide their own equipment to conduct the teletherapy session. This includes a computer or tablet device, a webcam or camera built into their device, and internet access to conduct the session. It is Therapist's responsibility to provide similar equipment for their use to conduct the session.

3. It is the responsibility of the client to ensure the environment chosen to conduct the teletherapy session is as private as possible and to keep distractions to a minimum. In addition, it is the responsibility of the client to protect confidential information within their own environment including preventing another person from listening in to the session. It is the responsibility of Therapist to do the same in her environment.

4. There will be no recording of an online therapy session and all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without the client's permission, except where disclosure is required by law.

5. Teletherapy based services and care may not be as complete as face-to-face services. If Therapist believes the client would be better served by another form of therapeutic services (e.g. face-to-face services), teletherapy services will be discontinued and the client will be offered in-office appointments. If it is not feasible for the client to travel to Therapist's office, then the client will be provided with referrals closer to their home.

6. Teletherapy is not a recommended method of treatment for emergency services. During the first session, Therapist and the client will discuss an emergency response plan. If the client is experiencing an emergency, the client or support person can call 911 or proceed to the nearest hospital emergency room for assistance. If the client is having suicidal thoughts or making plans to harm themselves, the client and/or support person can call the National Suicide Prevention Lifeline at 1-800-273-8255 for free 24-hour hotline support.

7. Teletherapy sessions are conducted via Zoom, GoToMeeting, Doxy.me or other platforms which are videoconferencing solution that are compliant with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). These videoconferencing platforms provide encryption, and protect patient data via HIPAA, which is the reason it is chosen over Skype or other alternatives. Clients are required to use these services to connect online for teletherapy. Dr. Liz will provide you with the link for your session.

Initial ___

By signing this form, you agree to have read, to understand, and to agree to the information presented above:

____
Client's Name

____
Client/Legal Guardian Signature

____
Date