

# Burson Counseling

Jackie Burson, MS, NCC, LPC, RPT & Brooke Komar, MS, LPC, LMHC, ATR

## NEW ADULT CLIENT INFORMATION

Name of Client \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_ Race\_\_\_\_ Religion \_\_\_\_\_

Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Job Title \_\_\_\_\_ Education (Yrs Completed) \_\_\_\_\_

Marital Status (Circle): Single / Married / Separated / Divorced / Widowed / Cohabiting

Name of Spouse \_\_\_\_\_ No. of years married \_\_\_\_\_

### Spouse Information (if applicable)

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_ Race\_\_\_\_ Religion \_\_\_\_\_

Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State/Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Education (Yrs. Completed) \_\_\_\_\_

Job Title \_\_\_\_\_

### Children

Full Name	Sex	Age	Comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who is currently living in your home?

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Who referred you to counseling? \_\_\_\_\_ Referral Date \_\_\_\_\_

How did you find me?

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Why are you currently seeking counseling?

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List your current concerns in the order of their importance (that brought you to counseling)

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Is there a history of any of the following? (Please check all that apply)

- Suicide Attempts
- ADD / ADHD
- Major Depression
- Grief Issues
- Anxiety
- Sexual Abuse
- Domestic Violence Contact with Child Protective Services
- Drug or Alcohol Abuse or similar agency
- (Self or Family) Other \_\_\_\_\_

What do you hope to gain from counseling at this time?

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Have you had any previous counseling? \_\_\_\_\_ If so, where and when and with regard to what issues?

Name of previous therapist \_\_\_\_\_

Address \_\_\_\_\_

Dates of therapy? From \_\_\_\_\_ To \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Issues of concern

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Reason for termination of therapy

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### Medical History

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Current Medications

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Check the behaviors and symptoms that occur to you more often than you like them to take place:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> aggressions         | <input type="checkbox"/> fatigue             | <input type="checkbox"/> sexual difficulties   |
| <input type="checkbox"/> alcohol dependence  | <input type="checkbox"/> hallucinations      | <input type="checkbox"/> sick often            |
| <input type="checkbox"/> anger               | <input type="checkbox"/> heart palpitations  | <input type="checkbox"/> sleeping problems     |
| <input type="checkbox"/> antisocial behavior | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> speech problems       |
| <input type="checkbox"/> anxiety             | <input type="checkbox"/> hopelessness        | <input type="checkbox"/> suicidal thoughts     |
| <input type="checkbox"/> avoiding people     | <input type="checkbox"/> impulsivity         | <input type="checkbox"/> thoughts disorganized |
| <input type="checkbox"/> chest pain          | <input type="checkbox"/> irritability        | <input type="checkbox"/> trembling             |
| <input type="checkbox"/> depression          | <input type="checkbox"/> judgment errors     | <input type="checkbox"/> withdrawing           |
| <input type="checkbox"/> disorientation      | <input type="checkbox"/> loneliness          | <input type="checkbox"/> worrying              |
| <input type="checkbox"/> distractibility     | <input type="checkbox"/> memory impairment   | <input type="checkbox"/> other (specify)       |
| <input type="checkbox"/> dizziness           | <input type="checkbox"/> mood shifts         | <input type="checkbox"/> cutting               |
| <input type="checkbox"/> drug dependence     | <input type="checkbox"/> panic attacks       | _____  |
| <input type="checkbox"/> eating disorder     | <input type="checkbox"/> phobias/fears       | _____  |
| <input type="checkbox"/> elevated mood       | <input type="checkbox"/> recurring thoughts  | _____  |

List additional illness, physical conditions or complaints:

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**PROFESSIONAL DISCLOSURE STATEMENT-BursonCounseling**  
**Jackie Burson, MS, NCC, LPC, RPT & Brooke Komar, MS, LPC, LMHC, ATR**

**Therapy Policies and Services**

Welcome! We are committed to providing you with quality care. This information packet is intended to acquaint you with what you can expect, and address some of the typical areas of concern, especially for the first-time client.

**Qualifications:** Jackie Burson is a graduate from Texas Woman's University in Counseling and Development. Brooke Komar is a graduate from Emporia State University in Art Therapy. We are qualified to counsel according to the Texas Department of Health. Our formal education has prepared us to do individual counseling with children, adolescents/teens, adults and families.

**Experience:** Throughout our master's program and under supervision since completing our formal education, we have counseled many individuals, family and group sessions in the school and agency setting, clinical internships, and in private practice.

**INFORMED CONSENT**

**Counseling Relationship:** While we work together, our sessions may be very intimate psychologically, but ours is a professional relationship rather than a social one. Please do not invite us to social gatherings, offer us gifts, ask us to write references for you, or ask us to relate to you in any way other than the professional context of our counseling sessions. You will be best served if our sessions concentrate exclusively on your concerns. Our in-person contact will be limited to counseling sessions you arrange with us. You may leave messages for me at 214-926-2184 and I will return your call as soon as possible. If you experience a mental health emergency, obtain crisis services by calling 911 and/or by going to a nearby hospital emergency room.

**Effects of Counseling:** At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

**Client Rights:** Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though we do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of our counseling techniques or suggestions that you believe might be harmful.

We assure you that our services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with our services, please let us know. If we are not able to resolve your concerns, you may report your complaints to the Texas Department of Health, 512-834-6658.

**Conditions of Ongoing Counseling:** If you have been in counseling or psychotherapy during the past seven years, we may require you to sign a release so we may communicate with and/or receive copies of records from the professional(s) from whom you received mental health services. While you are in counseling with us you agree not to maintain or establish a professional relationship with another mental health professional unless you first discuss it with us and sign a release that enables us to communicate with the other mental health professional(s). If you decide to maintain or establish a professional relationship with another mental health

professional against my advice, we may consider this your decision to change counselors and reserve the right to terminate your counseling.

We also reserve the right to postpone and /or terminate counseling of clients who come to session under the influence of alcohol or drugs. In addition, we reserve the right to terminate counseling of clients who do not comply with the medication recommendations of their psychiatrist or physician.

**Referrals:** We recognize that not all conditions presented by clients are appropriate for treatment at this facility. For this reason, you and/or we may believe that a referral is needed. In that case, we will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and /or alternatives. Certain aspects of treatment may require evaluation through psychological testing or medication. In such cases, a referral to a psychiatrist or medical doctor may be made. Ongoing dialogue with these professionals would be maintained to manage the counseling process effectively.

**Fees:** In return for a fee of \$ 120 per 50 minute session, we agree to provide counseling services for you. By consenting to treatment, you acknowledge (to you or your minor child) and agree to pay them at each session. Cash, credit cards or personal checks made out to “*Jackie Burson*” are acceptable for payment and due by the end of each session. Some insurance companies may cover part of this cost. You will be given a receipt at the end of your session for use in filing insurance claims.

If you become involved in litigation that requires our participation (even if the subpoena is sent from the opposite side of the case), and due the complexity and difficulties of legal involvement, **we charge \$250 per hour for preparation for and/or attendance at any legal proceedings. (A \$500 fee is due upfront before going to court).** There is a \$25 returned check fee.

**Cancellation: If you need to cancel an appointment, 24 hours notice is required. If you miss an appointment without sufficient notification you WILL BE CHARGED \$100. Missed appointments CANNOT be filed with insurance.**

**Records and Confidentiality:** All of our communication becomes part of the clinical record. Adult client records are disposed of seven years after the file is closed. Minor client records are disposed of seven years after the client’s 18<sup>th</sup> birthday. Most of our communication is confidential, but the following limitations and exceptions do exist: a) We determine that you are a danger to yourself or someone else; b) you disclosed abuse, neglect, or exploitation of a child, elderly, or disabled person; c) you disclose sexual contact with another mental health professional; d) We are ordered by a court to disclose information; e) you direct me to release your records; or f) We are otherwise required by law to disclose information. If we see you in public, we will protect your confidentiality by acknowledging you only if you approach us first.

\_\_\_\_\_  
Client’s Signature (parent if under 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor’s Signature

\_\_\_\_\_  
Date

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**HIPPA NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective August 1, 2004

**Use and disclosure of protected health information for the purposes of providing professional counseling services is sometimes required.** Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

**Treatment**

Use and disclose health information to:

- \_ Provide, manage or coordinate care to consultants, referral sources, or physicians.
- \_ As patients gives permission via "Informed Consent" form.

**Healthcare Operations**

- \_ Use and disclose health information for:
  - \_ Review of treatment procedures.
  - \_ Review of business activities.
  - \_ Staff training and care within our practice.
  - \_ Compliance and licensing activities.

**Other Uses and Disclosures Without Your Consent**

- \_ Mandated reporting.
- \_ Emergencies.
- \_ Criminal damage.
- \_ Appointment scheduling.
- \_ Treatment alternatives.
- \_ As required by law.

By signing below, you attest that you have read and have been made aware of my rights of confidentiality as a mental health consumer. Full HIPPA Compliance Rules and Regulations are posted in the therapist's office at all time, and may be read and copied for consumer upon request.

\_\_\_\_\_  
Client/Guardian Printed Name

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Client/Guardian Signature

\_\_\_\_\_  
Date Signed