MIND OVER MATTERS
Counseling Solutions
Rosanne C. Juarez M. Ed. LPC-S

2219 Sawdust Ste. 1101 The Woodlands, TX 77380
Phone: 832-766-0995 Fax: 832-299-5899
E-Mail: rjuarezcounsels@gmail.com
Web: mindovermatterssolutions.com

Information, Consent, and Policies

I am honored you have chosen this practice to provide you with counseling services. I will do my best to render you a purposeful experience that is beneficial and rewarding. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

Background Information

I have been working in the field of psychology since 1997. I have a B.A. in Psychology earned from the University of Alaska-Fairbanks. I received a M.A. in Educational and Clinical Counseling from the University of St. Thomas-Houston and I am a Licensed Professional Counselor and certified LPC Supervisor, licensed by the Texas State Board of Examiners of Professional Counselors. I have a certification in Sport Psychology from California Southern University.

My treatment approach is very active and engaged. It is generally a Cognitive-Behavioral approach, which incorporates a teaching model that helps clients with problem-solving strategies and effective coping skills for working through depression, fear, grief, anxieties, and many other life conflicts. Sessions emphasize the understanding and modification of patterns of thinking and behavior to enhance personal growth and insight as well as improving quality of life. I enjoy teaching effective communication with partners/spouses, children, parents, families, peers, and colleagues. I truly consider it an honor to be invited into a person's life and to be able to join in their journey of growth in self and relationships.

Benefits and Risks

There are many benefits to counseling such as improving relationships, learning more helpful behaviors, and resolving past and present conflicts, etc. However, there also exits risks such as emotional discomfort at sharing personal and sensitive information. Therapy is not an exact science, while some clients need only a few sessions to reach their goals, others may require months or longer. This is truly an individual quest. The client and I will decide together when goals have been met and you are comfortable with ending counseling sessions. If at any time I feel the treatment needed is beyond my expertise, I will refer you to a capable source. As a client you may end our professional relationship at any time. I will be supportive of that decision.

Confidentiality

As a client you have the right to confidentiality. I value client's privacy and will keep all case records confidential in a safe and secure location. However, there are limits of confidentiality, as a service provider, I am obligated by law and/or professional ethics to report threats to self, threats to others, child abuse/neglect, elderly or dependent adult abuse/neglect, or client abuse by another service provider. In the event a court case is filed or on file, your case records may be formally requested by the court and I am obligated to honor these requests. In order to provide the best and most efficient services, I will use the DSM-V diagnosis that may be utilized and verbally shared along with other non-identifiable information with other professional colleagues for the purpose of consultation and supervision. Information about the diagnosis, evaluation, or treatment of a client may be disclosed only to authorized private health insurance personnel for release of payment. All communication transmitted via email is not secure or HIPAA compliant.

_____*Initial* I received a hard copy of Health Insurance Portability and Accountability Act (HIPAA) of 1996.
_____*Initial* I prefer to download a digital copy from U.S. Dept. of Health and Human Services website
https://hhs.texas.gov/health-human-services-agencies-notice-privacy-practices

Fees

The individual, family, or couple's initial intake session will be 60 minutes in duration at a rate of $100. Each subsequent session will be 45-50 minutes at a rate of $90. Traveling expenses for onsite services is $25. All fees are due at the time service is rendered. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. I do not provide consultation, evaluation or legal expert testimony in child custody, child visitation or molestation cases. If you require these services, I will be happy to refer you to professionals who work with these issues.

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Insurance Reimbursement

If I am a provider for your insurance then I will fill out forms and provide you with whatever assistance I can in helping you receive benefits to which you are entitled; however you, not your insurance company is ultimately responsible for full payment of my fees. Although HIPAA protects patient records, insurance companies often request information about patients' treatment. At a minimum, they usually require a clinical diagnosis, dates of service, and the type of service.

Appointments

Your appointment time has been specifically reserved for you and I do not usually call to confirm appointments. If you cannot keep a scheduled appointment, please cancel the appointment at least 24 hours in advance by calling or texting me at 832-766-0995.

Cancellations

At least 24 hours advanced notice for cancellations is appreciated, with the exception of serious illness; cancelling session with less than 24 hours notice will result in the client being charged $50 for the missed session. If you are late for a session, you will be given the remainder of your session and you are financially responsible for the full session. Please note that insurance companies do not pay for missed sessions, therefore, you will be charged the cancellation fee. Any and all costs incurred for returned checks will be the responsibility of the client.

Grievance Procedure

I strive to provide you exceptional service but if you are dissatisfied with your treatment you may report any complaints or grievances to:
Texas Behavioral Health Executive Council
Attn: Enforcement Division
1801 Congress Avenue Ste 7.300
Austin, Texas 78701

You may also email enforcement@bhec.texas.gov or call 1-800-942-5540 to request the appropriate form or obtain more information. *This email and number are for complaints only*.

By signing below, I acknowledge that I have read and agree to adhere to all the policies described above. I agree to pay for my services at the above outlined rates.

_____ _____

Client's Signature Date

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Personal Data Record

Client Name_____ Date of Birth_____

Address_____

City/State/Zip_____

Employer or School_____

May I leave a message at any of the following?

Cell phone? Circle one _____Yes No

Home phone? Circle one _____Yes No

Work phone? Circle one _____Yes No

Email address _____Yes No

Marital status of client

Married _____ How long? _____ Single_____

Divorced _____ How long? _____

Separated _____ How long? _____

Widow/widower_____ How long ago _____

Family and household members

Name	Age	Gender	Relationship	Living with you? Circle one
_____	____	_____	_____	Yes or No
_____	____	_____	_____	Yes or No
_____	____	_____	_____	Yes or No
_____	____	_____	_____	Yes or No
_____	____	_____	_____	Yes or No
_____	____	_____	_____	Yes or No

Emergency Contact

Name _____ Phone _____

Address _____ Alt phone_____

Relationship to client _____

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Credit Card Payment Authorization for Auto Charge

Name _____

Relationship_____

Address _____

Phone _____

MC/Visa No. _____CVV_____ Exp. Date_____

Signature of Authorized User _____

Consent for Treatment

Client Name _____ Date of Birth _____

I give full consent for myself, my child/adolescent or dependent due to legal guardianship to receive outpatient mental health services until I notify you of any changes or until it is determined the treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for the individual stated above.

_____ _____

Authorized Signature Date

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Intake Information

Name of Client _____ Date of Birth_____

What concerns bring you to counseling?_____

_____

_____

When did this begin?_____

Are you having any difficulties and/or stressors in your current job, home or at school? If so, please briefly describe those difficulties_____

_____

_____

How much does this problem impact your current daily activities_____, job performance_____, personal relationships_____ and/or academic progress_____? Place a number in the blank next to each category.

1-Not at All 2-A little bit 3-Moderately 4-Quite a bit 5-Extremely

Emotional/Behavioral Problems-States- mark all that apply

- angry ☐
- sad ☐
- happy ☐
- numb ☐
- curious ☐
- anxious ☐
- disobedient ☐
- impulsive ☐
- gleeful ☐
- guilty ☐
- confused ☐
- edgy ☐
- uninterested ☐
- few friends ☐
- frustrated ☐
- hyperactive ☐
- heartbroken ☐
- recent life transition ☐
- depression/isolation ☐
- extreme worrier ☐
- easily distracted ☐
- chronic lying ☐
- poor concentration ☐
- physically aggressive ☐
- self-injurious acts ☐
- insecure ☐
- frightened ☐
- panicked ☐
- self-conscious ☐
- optimistic ☐
- low self-esteem ☐
- destroys property ☐
- hallucinations - tactile, auditory, visual ☐
- gender identity problem ☐
- homicidal thoughts ☐
- suicidal thoughts, gestures, attempts ☐
- restricts food / over exercising ☐
- substance abuse - alcohol/drugs ☐
- sexual dysfunction ☐

What do you hope to gain from counseling?

_____

_____

_____

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Medical History

Significant medical problems during childhood _____

Current health and medical problems _____

Past medical problems include dates and age _____

Current medications/reasons _____

Physician's Name _____

Phone_____

Mental Health History

What current mental health services (counseling and/or psychiatrist) are you receiving include names and phone numbers?

_____

_____

It is my practice to coordinate care with the client's physician/psychiatrist when this would be helpful. If you agree that we may contact your physician/psychiatrist, please initial here _____ A release of information must also be signed for this purpose.

What mental health services have you received in the past? Include dates.

_____

_____

What have you been diagnosed with- current or past? _____

Family past psychiatric history _____

Substance Use

How often do you drink alcohol? _____ How much per sitting? _____

Have you ever used or abused any drugs in your life? Describe

_____

_____

Have you ever had any treatment related to substance use? Describe

_____

_____

Please indicate if you have any family-current or past who have an alcohol or drug problem.

_____

_____

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Traumatizing Life Events

Have you experienced any history of significant abuse (physical, emotional or sexual)? Please briefly describe

_____

_____

_____

Do you have any history of significant life events such as deaths, separation from parents, frequent moves, and terminal illnesses in the family or close friendship?

_____

_____

_____

Educational History

Highest degree earned _____

Current school attending _____Grade _____

Average grade performance _____

Overall motivation to attend school _____

Extracurricular activities/hobbies _____

Additional Comments or Concerns

_____

_____

_____

_____ _____

Signature Date