Marilyn H. Stinson, PhD
Licensed Psychologist, LMSW, LPC
6208 W. Poly Webb Rd.
Arlington, Texas 76016
(817) 483-0020 / (817) 572-6676 Fax

ADULT INTAKE PAPERWORK

Adult intake paperwork: Please read and keep pages 1-3 that are general information about the counseling process and pages 8-10 on rights to privacy of your health care information (HIPAA). Prior to your 1st appointment please **completely fill out pages 4-6** and **sign page 7 in the appropriate places**; then give completed pages 4-7 to the office staff.

About Dr. Marilyn Stinson

Marilyn H. Stinson, PhD is a Licensed Psychologist, Licensed Clinical Social Worker (LCSW) and a Licensed Professional Counselor (LPC). Dr. Stinson received her Master of Social Work from the University of Texas at Arlington and her PhD in Counseling Psychology from Texas Tech University. She provides individual, marital, and family counseling to adults and some adolescents.

Therapy Expectations

Your first therapy session is a time for us to discuss your reasons for seeking counseling and to gather adequate information from you to set goals and to make a treatment plan for your mental health care. If other goals surface in future sessions, I will discuss these with you as they arise. The usual appointment schedule is once a week. With your permission I will often assign homework to aid in your healing. I take homework seriously and ask that you be ready to initiate a discussion of your homework at the next session.

It is your responsibility to share any relevant information about yourself and your situation that could help me understand how best to help you. If I do not directly ask you about a matter that could aid in treatment, please volunteer this information instead of waiting for me to ask just the right question. If a topic comes up that I seem to not adequately focus on in that session or in future sessions, please bring up the topic again as many times as you feel is necessary. This is both your right and your responsibility to yourself.

At your first session, we will agree on a regular day and time for your appointment. Counseling sessions are 45 minutes. To maintain the secure frame, we will hold you to that time. If you arrive late, we will still stop at the agreed time. If, on the other hand, I am running late, you will be given your full appointment time. Fees and times may seem incidental to the actual therapy; but consistency aids in your growth and healing and also contributes greatly to your sense of security. If your schedule is constantly changing, you will find that it is difficult to get much work done in therapy, and you will likely find yourself with subtle feelings of discomfort. If, however, these details remain solid and secure, you will feel a sense of health, safety, strength, and progress in your healing and growth as a person.

As therapy progresses there is often a "phasing out" process where you come to therapy less often as you begin to achieve your goals for treatment (i.e. initially come weekly, then every other week and then monthly). If you continue therapy after our initial session, I ask for a commitment that you not end treatment without a face-to-face discussion. A phone call or cancellation of a session to end treatment is not in your best interest in working through your personal or therapeutic concerns. All clients are asked to come in to have a final termination session to discuss progress and gain closure to the counseling process.

Unattended Children

Due to the nature of the therapeutic process, a quiet, peaceful and private atmosphere is necessary. Children left in the waiting area while parents are in session may be disruptive to other waiting clients as well as other clients in session, and may also be a distraction to our office staff. Therefore, it is our office policy that no children be left unattended in our offices at any time.

Cell Phone Use

To protect the privacy and therapeutic process of our clients and maintain the appropriate clinical atmosphere, please turn off your cell phone while in our offices. Should you need to make a call, you may step outside the building to make the call. However, it is best if you can postpone any calls until your appointment is concluded.

Fees and insurance

The cost of counseling is **$150.00** for a **45 minute** session. Checks, cash, and most credit cards are accepted at the time services are rendered. Clients are expected to pay the full fee at the end of each session. If you have insurance that covers mental health care, with your written permission and assignment of benefits we will be happy to file a claim to your insurance company. If your carrier denies payment for services rendered, you're responsible for any amount not covered, regardless of previous quotes by your insurance company.

Fees for Missed Appointments

Since your progress in therapy is often affected by your consistency in attending counseling sessions, it is strongly suggested that you make every effort to adjust your schedule so you will be able to keep scheduled appointments. However, if you are unable to keep an appointment, please notify the office immediately at 817-483-0020 to cancel or reschedule with the administrative assistant. If an appointment is scheduled for Tuesday through Friday and is cancelled or missed **without 24 hours' notice** you are responsible for the **full fee of $150**. If your appointment is on Monday, you must cancel before the same hour of your appointment on Friday. Third parties such as insurance companies and churches cannot be charged for any part of services not rendered. Timely cancellations allow your reserved time to be offered to someone else who could benefit from counseling.

After-Hours and Emergencies

I am NOT on 24 hour call. I do not see clients in the evening or on weekends. After-hours and weekends are reserved for my family. Any questions about scheduling will be answered by staff. Otherwise please wait until your next scheduled session to discuss any personal issues or concerns. If you have a mental health emergency please call 911, go to the hospital or call your local crisis hotline.

Privacy and Confidentiality

You can expect privacy and confidentiality with any information you give during the counseling process. Unless the laws and regulations of Texas require me to do so, under no circumstances may I ever reveal, without your permission, even the fact that you are a client. I cannot give any information at all about you or your case to anyone except for the exceptions on limits of confidently outlined in the HIPPA information you are given. There may be instances when you choose to allow information to be released to a professional, relative, friend or other person you have a relationship with to aid in your care; in that case, you must sign a release form.

Client/Therapist Relationship

A client and therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. I can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

Friending: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Adding clients as friends on these sites can compromise your confidentiality and our therapeutic relationship.
Following: I will not follow any client on Facebook, Twitter, Instagram, Tumblr, or other apps/websites. If there is content you wish to share from your online life, please bring it into our sessions where we can explore it together.
Location-Based Services: To protect your privacy, do not check-in at my office on Facebook, Foursquare, Google+, or any other location-based service. If you have enabled location services on your mobile phone, check-ins on such services could make it possible for others to surmise you are a counseling client at my office location.

Duty to Warn/Duty to Protect

If you are in any physical or emotional danger to yourself or another human being, I will contact any person who is in a position to prevent harm to you or another, including, but not limited to, the person in danger. This includes any medical or law enforcement personnel deemed appropriate.

Other Questions

I look forward to working with you in a therapeutic relationship. It has been my experience that counseling often makes a significant difference in a person's life. I believe it is an investment in yourself and others that may bring great benefits.

Please feel free to bring up any concerns in regard to therapy or the therapeutic process or payment matters. Treatment matters should be addressed to me as your psychologist and payment matters to the office staff, unless there is a specific reason for me to be involved.

Marilyn H. Stinson, PhD
Licensed Psychologist, LMSW, LPC

CLIENT INFORMATION

TODAY'S DATE:_____

NAME:_____ _____ _____AGE:_____D.O.B.:_____
*(**First**)* *(Middle Initial)* *(Last)*

ADDRESS:_____CITY: _____STATE: ____ZIP: _____

CELL #: (____)_____ HOME #: (____)_____ WORK #: (____)_____

EMAIL:_____ SOCIAL SECURITY #:_____
*(**PLEASE print <u>clearly</u**)*

OCCUPATION:_____ EMPLOYER:_____

CURRENT MARITAL STATUS: Single/Never Married \ Married \ Partnered \ Widowed \ Divorced
 # OF TIMES MARRIED:_____ # YEARS OF CURRENT MARRIAGE _____

SPOUSE'S NAME:_____ AGE:_____ D.O.B.:_____

OCCUPATION:_____ EMPLOYER:_____

SPOUSE'S CELL #: (____)_____ WORK #: (____)_____

CHILDREN (*NAMES AND AGES***):_____**

NEAREST RELATIVE <u>*NOT*</u> LIVING WITH YOU:_____ RELATIONSHIP:_____

ADDRESS:_____PHONE #: (____)_____
(Street) *(City)* *(State)* *(Zip)*

PHYSICIAN: _____ PHONE #: (____)_____

CURRENT MEDICATIONS (*AND DOSES***):_____**

_____

DESCRIBE ANY IMPORTANT <u>MEDICAL</u> HISTORY, CHRONIC AILMENTS, OR OTHER HEALTH PROBLEMS YOU EXPERIENCE: _____

_____

WHO REFERRED YOU TO THIS OFFICE?_____RELATIONSHIP:_____

Marilyn H. Stinson, Ph. D.

Licensed Psychologist, LMSW, LPC

TODAY'S DATE: _____ *CLIENT'S NAME:* _____

PROBLEM(S) SEEKING COUNSELING FOR: _____

PLEASE LIST YOUR COUNSELING GOALS: _____
_____
_____

ANY PREVIOUS COUNSELING?_____(*If yes*) **WHOM DID YOU SEE?**_____

WHEN?_____**FOR WHAT PROBLEM(S) DID YOU SEEK COUNSELING?**_____

PLEASE PLACE AN "X" BY ANY OF THE FOLLOWING THAT APPLY TO YOU: *Relationship Problems_____; Physical Health Problems_____; History of Physical Abuse_____, Sexual Abuse_____, Emotional Abuse_____, Spiritual Abuse_____; Previous Mental Health Problems_____; Alcohol Abuse by Self_____ or Family Member_____; Substance Abuse by Self _____or Family Member_____; Mental Illness in Your Family_____; Suicide Attempt(s) by Self_____ or Family Members_____.*

DO YOU USE RECREATIONAL DRUGS? YES \ NO **IF NO, HAVE YOU USED PREVIOUSLY?** YES \ NO **IF YES, WHEN DID YOU STOP? _____TYPE OF DRUG USE NOW OR PREVIOUSLY _____ HOW MUCH _____HOW OFTEN_____**

DO YOU DRINK ALCOHOL? YES \ NO **IF NO, DID YOU DRINK PREVIOUSLY?** YES \ NO
IF YES, WHEN DID YOU STOP? _____ TYPE OF ALCOHOL NOW OR PREVIOUSLY _____HOW MUCH _____HOW OFTEN_____

DO YOU SMOKE CIGARETTES? YES \ NO **HOW MANY A DAY? _____**
DO YOU SMOKE ELECTRONIC CIGARETTES? YES \ NO
DO YOU USE OTHER FORMS OF TOBACCO? YES \ NO **WHAT TYPE? _____**

DID YOU EXPERIENCE ANY DEVELOPMENTAL, ACADEMIC OR BEHAVIOR PROBLEMS AS A CHILD OR WHILE IN SCHOOL, WITH PEERS OR TEACHERS? YES \ NO **IF YES, PLEASE EXPLAIN:** _____
_____
WHAT WAS THE LAST YEAR OF SCHOOL YOU COMPLETED? _____

HOW WOULD YOU DESCRIBE YOUR CURRENT SUPPORT NETWORK? (FRIENDS, RELATIVES, ETC.): _____
_____

DESCRIBE ANY FAMILY PROBLEMS WHICH OCCURRED WHILE GROWING UP RELATING TO: Alcohol / drug abuse; Sexual / physical / emotional /spiritual abuse: _____
_____
_____
_____

Marilyn H. Stinson, Ph. D.
Licensed Psychologist, LMSW, LPC

TODAY'S DATE: _____ *CLIENT'S NAME:* _____

HAVE YOU HAD ANY CHANGE IN SLEEPING HABITS YES \ NO **or EATING HABITS?** YES \ NO **DESCRIBE:** _____

HAVE YOU EVER CONSIDERED SUICIDE IN CONNECTION TO YOUR CURRENT PROBLEM? YES \ NO **HAVE YOU EVER CONSIDERED SUICIDE IN THE PAST?** YES \ NO **HAVE YOU ATTEMPTED SUICIDE RECENTLY OR IN THE PAST?** YES \ NO **IF YES TO ANY OF THESE, PLEASE BRIEFLY EXPLAIN WITH DATES:** _____
_____
_____

HAVE YOU HAD ANY HOMICIDAL THOUGHTS RECENTLY OR IN REGARD TO YOUR CURRENT PROBLEM? YES \ NO **HAVE YOU EVER CONSIDERED HOMICIDE IN THE PAST?** YES \ NO **IF YES, PLEASE EXPLAIN:** _____
_____
_____

LEVEL OF FUNCTIONING: LIST OR DESCRIBE ANY CURRENT PROBLEMS IN DAILY PSYCHOLOGICAL, SOCIAL OR OCCUPATIONAL FUNCTIONING (i.e. isolation from friends/family, significant difficulty getting to work or school or completing daily tasks, severe financial strain, recent divorce, problems with supervisor, death of a family member, close friend or pet, etc.**):**
_____
_____
_____
_____

THOUGHTS: PLEASE MARK YES TO ANY OF THE FOLLOWING THAT APPLY TO YOU:
YES \ NO **I sometimes hear voices even though no one nearby is talking to me.**
YES \ NO **I sometimes feel that forces outside of me control me.**
YES \ NO **I sometimes feel that other people control my thoughts.**
YES \ NO **I sometimes have the same thought over and over and cannot control it.**
YES \ NO **I sometimes feel that someone is out to hurt me or do something against me.**
YES \ NO **I am sometimes unable to control my behavior.**
PLEASE EXPLAIN: _____
_____
_____

ANY OTHER PERTINENT INFORMATION? _____
_____
_____

Thank you! We appreciate you taking time to fill out pages 4-6 thoroughly.
Please sign the appropriate places on page 7 and give ***pages 4-7*** *to the office staff.*

Marilyn H. Stinson, Ph.D.
Licensed Psychologist, LMSW, LPC
6208 W. Poly Webb
Arlington, Texas 76016
817-483-0020

Acknowledgement of Receipt of HIPPA Information

I have received Dr. Marilyn H. Stinson's notice of "Policies and Practices to Protect the Privacy of Your Health Care Information" as well as general information on her practice.

_____ _____
Printed Name Signature

_____
Date

Assignment of Insurance benefits

If you think at any point you want our office to file claims with your insurance company please sign below.

I authorize your office to file claims, giving necessary information to my insurance. I assign benefits received that apply to my therapy sessions to Marilyn H. Stinson, PhD.

_____ _____
Printed Name Signature

_____
Date

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Consent to Treatment for Self

By signing this Client Information and Consent Form as the Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I am voluntarily agreeing to receive mental health assessment, treatment and services. I understand that I may stop such treatment or services at any time but am requested to have a termination session in person before ending treatment.

_____ _____
Printed Name Signature

_____
Date

Marilyn H. Stinson, Ph.D.
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Policies and Practices to Protect the Privacy Of Your Health Information (HIPAA compliance)

This notice describes how psychological, mental health and any other information about you may be used and disclosed by me or my office and how you can get access to this information. Please review it carefully.

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

We may *use* or *disclose* your *protected health information* (*PHI*), 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 we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician, psychiatrist, or other health care provider.

- *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

- *Health Care Operations* are activities that relate to the performance and operation of my 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 within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our clinic such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy or counseling notes. *"Psychotherapy or counseling notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on

that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against me with one of our state regulatory boards they have the authority to subpoena confidential medical or mental health information from us relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The 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, my office may disclose relevant confidential mental health information to medical or law enforcement personnel.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are getting treatment. Upon your request, we will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. When several patients are seen together in a therapy session (conjoint marital therapy, family therapy, etc.), without a subpoena from a court, we cannot release records from these sessions without a signed release from each adult present for that particular session. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an 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, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Dr. Marilyn Stinson's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise our policies and procedures, we will provide an updated policy during your next visit or will mail a copy to your home address.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Dr. Marilyn H. Stinson, (817-483-0020).

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to Dr. Marilyn H. Stinson, 6208 W. Poly Webb Rd., Arlington, TX 76016.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services or Texas State Boards for my licenses (Psychology, Social Work, and Professional Counselor). I can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice is in effect and updated on July 1, 2018.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will either hand deliver the revised notice or mail it to you.