Denise Lopez
Licensed Professional Counselor Associate
Supervised by Rolla Bradley Jr., LPC-S
6208 W. Poly Webb Rd.
Arlington, Texas
817-330-4919

Method of Treatment:

I believe the counseling process is a collaborative partnership between the therapist and the client based on trust and mutual respect. As I take this journey with you, we will explore your current concerns, identify hindering beliefs and behaviors, and work together to create and reach your goals.

My approach to counseling is an integrative approach based on the needs of each individual client. Within this framework, I hope to build a relationship with you that is empathic and encouraging. I desire to understand your beliefs and feelings, and work with you to develop insight into your life.

I believe each person has been affected by experiences and people in their past. Therefore, I take care to explore the impact of "family of origin" issues as it can help us understand what we believe about ourselves, others, and the world. Many of us, (either knowingly or unknowingly) hold innate feelings of inferiority and attempt to overcome them by behaviors that may hinder our emotional health. My hope is to journey with you toward greater health by identifying beliefs and behaviors that might be keeping you from the life you want to live. I believe every person holds the power to change and make positive decisions and developing an awareness of our internal notions and why we do what we do is the first step. It is my joy to join you on this journey.

Length of Treatment:

The length and nature of therapy is different for every client. Each individual has unique strengths and weaknesses, and each concern is different from the next. Some clients achieve their goals in only a few counseling sessions, whereas others may require months or even years of counseling.

Goals, Risks, and Benefits

Therapy can have both benefits and risks. Since it often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, or helplessness. Counseling is a time of personal exploration that may lead to significant changes in your life perspectives and decisions. These changes may affect your relationships, your job, and/or your understanding of yourself. It is my role to help you cope with the changes and challenges you may encounter.

However, therapy often leads to benefits such as improvements in self-awareness, self-esteem, self-confidence, hope, relationships with other people, emotional expressiveness, and taking an

active and responsible role in one's life. It can provide solutions to specific problems and lead to significant reductions in feelings of distress. Please note, however, that it is impossible to guarantee any specific outcomes regarding your counseling goals. Together, we work to achieve the best results possible.

Our Relationship
I respect the confidentiality of our counseling relationship. For this reason, if I see you in public, I will protect your confidentiality by greeting you only if you greet me first.

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.

Emergencies
If you have a mental health emergency, please call 911, go to your local emergency room, or call your local crisis hotline. It is your responsibility to seek the appropriate resources in emergency situations.

Fees and Financial Policy

I, the undersigned, have requested services from Denise Lopez, LPC Associate. I agree to pay for services at the following rates and to abide by the terms outlined in this contract.

Counseling session for 50 minutes	$150.00
Missed Appointments without a 24 hour notice	$150.00

Court Appearance $500.00 per hour with 5-hour minimum plus travel expenses ($.60/mile plus $75 per day per diem). Minimum payment for this service is expected at least one week **PRIOR** to the scheduled date. **NO REFUNDS** The records fee is $125.00 per request. All requests must be made in writing.

Limits of Confidentiality:
The laws of the State of Texas require that most issues discussed during the course of counseling with mental health providers are confidential. These laws permit you to have privilege of confidentiality by signing a "Release of Information" form. However, there are situations when your confidentiality is not guaranteed. These situations include the following. Please **initial** the lines below indicating your agreement with these limits of confidentiality.

_____ 1. Under certain circumstances your file can be subpoenaed by the courts.

_____ 2. If you intend to harm yourself or someone else and verbalize this threat, I am permitted by law to notify the proper authorities, and you hereby grant me permission to do so.

_____ 3. Any report of injury to a child, an elderly person, or a disabled person, must be reported to the proper authorities.

_____ 4. I may consult with another counselor about your case. Every attempt is made to ensure identity remains anonymous. In addition, the counselor with whom I consult is held to the same limits of confidentiality outlined here.

_____ 5. If you are a minor, your parent(s) are the holders of confidentiality. In other words, everything a minor tells a counselor can be told to the parent(s). However, in order to work most effectively with a minor, I request that the parent(s) allow me to determine what I will disclose to them. If your parent(s) agree, I will then inform your parent(s) only of any life-threatening activity. In that event all other information discussed by you with me in counseling will be kept confidential.

By signing this form, you confirm that I have informed you of the limits of confidentiality, that you have had your questions answered, and have agreed with these limits.

Additionally, your signature is an acknowledgement that you have received a HIPAA disclosure and have read, been given opportunity to ask questions, understand, and agree with its contents.

_____

Signature of Client (or person acting for client) Date

_____

Printed Name Relationship to client (if necessary)

_____ _____

Signature of Counselor Date

Date of first appointment: _____

Name:_____DOB:_____
Phone:_____Address:_____
_____
Email:_____

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:_____

Have you previously received any type of mental health services? _____Yes _____No

If yes, which of the following:
_____Counseling _____Medication _____Outpatient Hospitalizations _____Inpatient Hospitalization

If yes, please provide:
Name of provider or facility_____
Location_____
Dates of treatment_____
Reason for treatment_____

Briefly, what led you to booking an appointment?

When did your challenge first start? Within the last:
_____30 days
_____6--12 months
_____2 years
_____During adolescence
_____During childhood

What areas of your life have been affected because of this challenge?

Are you currently experiencing overwhelming sadness, grief or depression? _____Yes _____No
If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? _____Yes _____ No
If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in counseling?

Family History

Please list your parents and siblings. (Please use additional space on the back if needed.)

Name	**Age**	**Relationship**	**If deceased, age and cause of death**

Who did you live with while growing up and what was it like?

Mother's occupation:_____
Father's occupation:_____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	**Please Circle**	**List Family Member(s)**
Alcohol/Substance Abuse	Yes/No	
Depression	Yes/No	
Domestic Violence	Yes/No	
Sexual Abuse	Yes/No	
Eating Disorders	Yes/No	
Obesity	Yes/No	
Obsessive Compulsive Disorder	Yes/No	
Schizophrenia	Yes/No	
Suicide Attempts	Yes/No	
Other Diagnosed Mental Health Condition?	Yes/No Condition:	

Marital Status:
_____Never Married
_____Domestic Partner
_____Married, how long _____
_____Separated
_____Divorced
_____Widowed

On a scale of 1-10 (best), how would you rate your relationship? _____

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	**Dosage**	**Condition**	**Date Began/Stopped**

Prescribing provider and contact information:
Name: _____
Specialty: _____
Facility: _____
Phone, email, or Fax: _____

How would you rate your current physical health?
_____Poor _____Unsatisfactory _____Satisfactory _____Good _____Very Good
Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?
_____Poor _____Unsatisfactory _____Satisfactory _____Good _____Very Good

If you are having problems, in which phase of sleep are you experiencing issues?
_____Falling asleep _____Staying asleep _____Awakening early _____Sleep apnea
Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____
What types of exercise do you participate in:

Are you currently experiencing any chronic pain?
_____Yes _____No
If yes, please describe:

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Additional Information

What do you enjoy about your work (full-time homemaker included)?

If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time?

What do you do to relax?

Do you consider yourself to be spiritual or religious? (This could or could not be about church.)
If yes, please describe your faith or belief:

What do you consider to be some of your strengths and opportunities for growth?

Counselor's Name: Denise Lopez

License Number: 89194

Denise Lopez is a Licensed Professional Counselor-Associate (LPC Associate) in the state of Texas. as an LPC-Associate, she is supervised by Rolla Bradley, LPC Supervisor. If at any time you are dissatisfied with your counselor's services and they are not able to resolve your concerns, please let their supervisor know.

Your provider's LPC-Supervisor is:

Rolla Bradley, LPC-S
Rolla.Bradley@lifestance.com
844-824-8775

LPC-Associates practice under the authority of the Texas Behavioral Health Executive Council. If you have a complaint, you also have the right to file a grievance with the following agency:

Texas Behavioral Health Executive Council
George H.W. Bush State Office Bldg.
1801 Congress Ave. Ste. 7.300
Austin, TX 78701

Supervision Consent:

I understand the provider I/my child will be treated by is under clinical supervision which consists of weekly case reviews. All information divulged in the counseling session remains confidential. Both your therapist and their supervisor will respect your rights to confidentiality. I understand I have the right to address any issues with my provider's services with their LPC-Supervisor.

Date: _____

Signature: _____

Name of Patient Representative, if applicable: _____

Description of Patient Representative's Relationship to Patient, if applicable: _____