Richland Oaks
COUNSELING CENTER

Phone: 469-619-ROCC (7622)
Fax: 469-458-7024
Email: ROCC@richlandoaks.org
Website: richlandoaks.org

Richardson
1221 Abrams Rd. Ste. 325
Richardson, TX 75081

Plano
920 18th St.
Plano, TX 75074

McKinney
6401 Eldorado Pkwy, Ste 208
McKinney, TX 75070

Prosper
212 E. Broadway St.
Prosper, TX 75078

ASSESSMENT INTAKE PACKET (Adult)

Included in this Packet:

(1) Information & Consent Form (pp. 2-7)
(2) Notice of Privacy Practices (pp. 8-9)
(3) Acknowledgment of Receipt of NPP (p. 10)
(4) Intake Questionnaire (pp. 11-16)
(5) Credit Card Authorization Form (p. 17)

Instructions:

Before your Appointment:

(1) Read, Sign, and Date the **ROCC Office Copy** of the **Information & Consent Form** **(Keep the Client Copy that is printed for you)**
(2) Complete the **Intake Questionnaire**
(3) Review the **Notice of Privacy Practices (NPP)**
(4) Sign/Date the **Acknowledgment of Receipt of NPP**

Bring to your Appointment:

(1) The signed **ROCC Copy of the Information & Consent Form**
(2) The signed **Acknowledgment of Receipt of NPP**

If you have any questions regarding these forms, please call (469) 619-7622.

Assessment Information and Consent Form (Adult)

[Client Copy – Keep for your records]

Services Provided

Richland Oaks Counseling Center (ROCC) offers a variety of therapy and assessment services provided by psychologists, counselors, psychology post-doctoral and pre-doctoral interns, licensed professional counselor interns, and psychology and counseling graduate students.

Psychological Assessment

Psychological assessment provides the opportunity to evaluate an individual compared against normative samples in order to determine how similar or different they are from the normative group. The benefits of completing a psychological assessment may include obtaining a detailed description of strengths and challenges in the areas covered by the assessment (e.g., intellectual, academic, social-emotional functioning), and recommendations for addressing areas of difficulty. For example, this information might be useful to help a child qualify for special accommodations in his or her educational environment. Please note, as of 2015 in the state of Texas, psychologists (and any clinician in training) are not permitted to provide statements in court regarding appropriate custody of a minor, parental fitness (i.e. which parent is a psychologically better fit to raise the child), and/ or parental alienation unless they have had specialized training in this area (usually referred to as Forensic Psychologists). Please consult with your clinician regarding their training in this area.

Psychological assessment typically presents a relatively low risk to participants. It is possible that individuals may feel uncomfortable or anxious about being tested. Assessors are trained to detect and respond sensitively to indications of anxiety.

Psychological Assessments for minors attempt to include information from one and/or all parent(s), legal guardian(s), other caregivers, teachers, school counselors, physicians, and other medical or mental health providers.

Confidentiality

In keeping with professional ethical standards and state and federal law, all services provided by the staff of ROCC are kept confidential except as noted below and in the accompanying Notice of Privacy Practices. We consult as needed within the staff of ROCC about the best way to provide the assistance that you might need. As required by psychological practice guidelines and current standards of care, we keep records of all assessments. These records are stored securely in a manner consistent with federal and professional security standards for medical records. All requests for records should be done in writing, with a Release of Information form. Please be advised, a succession plan is in place if your clinician should become seriously ill, impaired in some capacity, or pass away unexpectedly.

ROCC professional staff have a legal responsibility to disclose client information without prior consent when a client is likely to harm himself, herself or others unless protective measures are taken, when there is reasonable suspicion of abuse of children, dependent adults or the elderly, when the client lacks the capacity to care for him or herself or when there is a valid court order for the disclosure of client files. Fortunately, these situations are infrequent.

By signing this form you also give ROCC permission to communicate with the Emergency Contact that you have designated if we believe that you are at risk. If you are suing someone or being sued, or if you are charged with a crime and you tell the court that you are a client at ROCC, ROCC or your assessor may then be ordered to show the court your records. Please consult your lawyer about these issues. Please consult with your assessor if you have questions about confidentiality.

Policies

In general, you may review your records in ROCC's files at any time. There are some limitations regarding raw testing data, but for the most part, you have access to your information. You may add to this information or correct this information, and you may have copies of the records. However, you may not examine records created by anyone else and sent to ROCC. In some very rare situations, parts of your records may temporarily be removed before you see them. This would happen if it is determined that the information would be harmful to you; nevertheless, the assessor or appropriate ROCC staff will discuss this with you if it becomes an issue.

ROCC is not an emergency or crisis intervention facility. In the event of an emergency or crisis between scheduled appointments, go to the nearest emergency room or seek help by calling Contact Counseling and Crisis 24-Hour Line at 972-233-2233 (adult) or 972-344-8336 (teens), the Suicide Crisis Center 24-Hour Line at 214-828-1000 (all ages), or call 911 if it is a life-threatening situation.

Fees for Service

Richland Oaks' clinicians are individually contracted with insurance companies. Not all clinicians take insurance, and some take only certain panels. If we are in-network with your insurance, we will attempt to verify benefits before your first session and file claims accordingly. Please note that we are only able to provide you with an estimate of benefits and the insurance company reserves the right for the final approval. You will be responsible for charges which are not covered or contracted by insurance. If we are not in-network, we will provide you with a Superbill, upon request, so that you may file with your insurance company.

There will be a fee of **$10** should you chose to request medical records. Medical records sent to another provider of services will not incur a fee.

Cancellation Policy

ROCC clinicians look forward to working with you. Our assessment sessions are approximately four (4) hours long. It is our strict policy to stay on time for all scheduled appointments. Therefore, if at all necessary, your wait time is kept to a minimum. Due to the length of time provided for each appointment, it is critical that you arrive on time for your appointments. If you are more than 20 minutes late, we will have no choice but to reschedule your appointment and you will be responsible for the fees of a no show. In order to avoid paying no show fees, we require at least forty-eight (48) hours' notice for all assessment cancellations, unless your appointment is on Monday, at which we cancellation needs to be before 3pm on the prior Wednesday. **Insurance companies will not pay for "No Shows or Late Cancellations," therefore you will be responsible for the $_____ fee for a missed appointment for the first no show or late cancellation.** After the **second** no show or late cancellation, you will not be able to schedule another appointment and will be referred to another provider.

Use of electronic mail/text features/social media

Please be aware that e-mail may not be private or confidential and may not be read by the recipient in a timely fashion. With regards to any client of ROCC (adult or minor), your clinician will not communicate therapeutic information via email. Not all clinicians have work phones with text features; however, if this feature is available only scheduling information should be discussed. Please ask your clinician if texting is an option. Clinicians work to protect your privacy, thus will not accept requests for connecting or messaging on social media sites.

Search Engines

It is not a regular part of our practice to search for clients on Google, Facebook, or other searchable sites. An exception could be during a crisis. If we have reason to suspect you are a danger to yourself or others and have exhausted all other reasonable means to contact you and/or your emergency contact, then we may use a search engine for information to ensure your welfare. If this ever occurs, it will be fully documented and discussed with you at your next session.

Location-Based Services

Please be aware if you use location-based services on your mobile phone you may compromise your privacy while attending sessions at the office. The office is not a check-in location on various sites such as Facebook, however it can be found as a Google location. Enabled GPS tracking makes it possible for others to surmise you are a client due to check-ins at the office location.

Psychiatric consults and medication

ROCC does not retain a psychiatrist on staff, nor do we prescribe or dispense psychiatric medications. ROCC can provide you with a psychiatric referral if deemed necessary. You may sign a release to enable ROCC to consult with your Psychiatrist.

ROCC is a training and research site for psychologists and counselors

ROCC is a training and research facility. Thus, the assessment you receive may be conducted in full or in part by a graduate clinical psychology student, pre-doctoral intern, post-doctoral fellow, or licensed psychologist. All assessors in training will inform you of their trainee status as well as the name of their supervising psychologist who can be contacted through our office. In order to adequately supervise trainees, a supervisor may ask that the assessment session be audio or video recorded.

Staff psychologists may also wish to record sessions for the purpose of training others but will ask your permission to do so. All recordings are kept confidential in the same manner as your assessment records and will be erased after supervisory review. You may choose not to have your sessions recorded. Please talk with your assessor if you have questions about audio and video recording.

ROCC utilizes psychological test data in archival research and the training of graduate students in mental health. Archival research is the study of past psychological test scores from your records to investigate scientific questions that arise in the future. This scientific investigation is generally aimed at improving treatment outcomes and increase our understanding of psychiatric conditions. This data will be collected, scored without your name being identified and without any personal information from which you may be identified. By signing this form you agree to allow the use of this data for research with the understanding that you will receive no financial benefit from the use of the archival data.

Consent

By signing below, I agree to allow myself to be evaluated by a qualified ROCC assessor. I understand the purpose of the interviews, psychological tests, and/or observations involved in the evaluation are to prepare a written psychological report concerning the assessor's professional opinion regarding my current functioning.

During the course of the evaluation, psychological testing is provided under standardized procedures and will take place under specific testing conditions. If for any reason I do not believe I can do my best, I agree to inform the assessor so that the evaluation can be stopped and rescheduled for a time when I will feel more comfortable. If you become tired, hungry, thirsty, or uncomfortable in any way during the evaluation, please encourage them to let the assessor know and you can be given an opportunity to take a break.

I understand I have the right **not** to sign this form. My signature below indicates I have read and discussed this agreement; it **does not** indicate that I am waiving any of my rights. I understand I can choose to discuss my concerns with the assessor before I begin any formal assessment. I understand that after the assessment begins I have the right to withdraw my consent at any time, for any reason. However, I will make every effort to discuss my concerns with the assessor before ending the assessment.

I understand that no specific promises have been made to me by the assessor or ROCC staff about the results of my assessment, the effectiveness of the procedures used, or the number of sessions necessary for the assessment to be completed. Information obtained during my evaluation will be confidential and privileged except for the limitations noted above. I understand that a report will be written and submitted to other professionals of my choosing. No other reports will be made except by my specific permission or by appropriate court order.

I, _____ (printed name) agree to enter into psychological assessment at Richland Oaks Counseling Center (ROCC) in accord with the policies outlined above. If self-pay, the total price for the assessment will be $_____.

_____	_____	_____
Client's Printed Name	Signature	Date

_____	_____	_____
Clinician's Printed Name	Signature	Date

Assessment Information and Consent Form (Adult)

[ROCC Copy – Retain for client records]

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_____	_____	_____
Client's Printed Name	Signature	Date

_____	_____	_____
Clinician's Printed Name	Signature	Date

Notice of Privacy Practices (NPP)

[Client Copy – Keep for your records]

This notice describes how mental health information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully.

Richland Oaks Counseling Center is a teaching and research clinic. Graduate counseling and clinical psychology students, psychology pre-doctoral interns and post-doctoral fellows, and licensed professional counselor interns may participate in your care as a part of their mental health training programs. All care is overseen and supervised by a licensed mental health professional. All information describing your mental health treatment and related health care services ("mental health information") is personal, and we are committed to protecting the privacy of the personal and mental health information you disclose to us. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. When we disclose information to other persons and companies to perform services for us, we require them to protect your privacy, too. This Notice also applies to your psychologist, counselor, psychiatrist and other health care professionals who provide care to you. We must also provide certain protections for information related to your medical diagnosis and treatment, including HIV/AIDs, and information about alcohol and other substance abuse. We are required to give you this Notice about our privacy practices, your rights and our legal responsibilities.

WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION:

- For Treatment. For example, we may give information about your psychological condition or assessment to other health care providers, such as your family physician or another psychologist, to facilitate your treatment, referrals or consultations.
- For Payment. For example, a health care provider may contact your insurer to verify what benefits you are eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.
- For Healthcare Operations For example, we may give information to University or professional mental health and training organizations to review the quality of care provided, for performance improvement or for the training of health professionals. Other examples could include audits and administrative services, and case management and care coordination.
- For Appointments and Services to remind you of an appointment or tell you about treatment alternatives or health related benefits or services.
- To Individuals Involved in Your Care. For example, your parents, if you are a minor, or your conservator.
- With your written authorization we *m*ay use or disclose mental health information for purposes not described in this Notice.

WE MAY USE YOUR MENTAL HEALTH INFORMATION FOR OTHER PURPOSES WITHOUT YOUR WRITTEN AUTHORIZATION:

- As Required by Law when required or authorized by other laws, such as the reporting of child abuse, elder abuse, disabled or dependent adult abuse.
- For health oversight activities to governmental, licensing, auditing, and accrediting agencies as authorized or required by law including audits; civil, administrative, or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.
- In Judicial Proceedings in response to court/administrative orders, subpoenas, discovery requests, or other legal process. If ROCC and/or your clinician is subpoenaed to appear in court and provide testimony regarding our knowledge and experience of you and our assessment, we will assert privilege on your behalf. Nevertheless, if the judge insists we testify, we will testify truthfully and honestly to our thoughts and professional opinion.
- To Public Health Authorities to prevent or control communicable disease, injury, or disability, or ensure the safety of drugs and medical devices.

- To Law Enforcement for example, to assist in an involuntary hospitalization process.
- To the State Legislative Senate or Assembly Rules Committees for legislative investigations.
- For Research Purposes subject to a special review process, and the confidentiality requirements of state and federal law.
- To Prevent a Serious Threat to Health or Safety of an individual. We may notify the person, tell someone who could prevent the harm, or tell law enforcement officials.
- To Protect Certain Elective Officers including the President, by notifying law enforcement officers of potential harm.

YOU HAVE THE FOLLOWING RIGHTS:

- To Receive a Copy of this Notice when you obtain care.
- To Request Restrictions. You have the right to request a restriction or limitation on the mental health information we disclose about you for treatment, payment, or health care operations. You must put your request in writing. We are not required to agree with your request. If we do agree with the request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment.
- To Inspect and Request a Copy of your Mental Health Record except in limited circumstances. A fee will be charged to copy your record. You must put your request for a copy of your records in writing. If you are denied access to your mental health record for certain reasons, we will tell you why and what your rights are to challenge that denial.
- To Request an Amendment and/or Addendum to your Mental Health Record**.** If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record) of no longer than 250 words for each inaccuracy. Your request for amendment and/or addendum must be in writing and give a reason for the request. We may deny your request for an amendment if the information was not created by us, is not a part of the information which you would be permitted to inspect and copy, or if the information is already accurate and complete. Even if we accept your request, we do not delete any information already in your records.
- To Receive an Accounting of Certain Disclosures we have made of your mental health information. You must put your request for an accounting in writing.
- To Request That We Contact You By Alternate Means (e.g., fax versus mail) or at alternate locations. Your request must be in writing, and we must honor reasonable requests.

CHANGES TO THIS NOTICE: Richland Oaks Counseling Center reserves the right to change or revise this Notice. If a revision is made to our policies and procedures, a revised copy will be posted in the office and a copy will be provided to you upon request.

CONTACT INFORMATION: If you have any questions about this Notice, please contact the office manager at Richland Oaks Counseling Center, 1221 Abrams Road, Suite 325, Richardson, Texas, 75081, or by telephone at 469-619-7622.If you believe your privacy rights have been violated, you may contact the Texas Board of Examiners of Psychologists at 1-800-821-3205 or the Texas Board of Examiners of Professional Counselors at 1-800-942-5540. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. **You will not be penalized for filing a complaint.**

Effective Date: May 1, 2012

Acknowledgment of Notice of Privacy Practices

[ROCC Office Copy – Keep for Client Record]

The Richland Oaks Counseling Center Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we will provide you, copies of the current notice may be obtained through the office manager at ROCC.

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Signature of Client or Client's Legal Representative *Date*

_____

Print Name

Interpreter (if applicable) _____*Relationship to Client* _____

Today's Date: _____ / _____ / _____
Month Day Year

INTAKE QUESTIONNAIRE:

Client Information

Legal Name: _____ _____ _____
First Name MI Last Name

Preferred Name/Nickname: _____

Birth Date: _____ / _____ / _____ **Current Age:** _____
Month Day Year

Contact Information:

Street Address _____

City _____ **Zip** _____

Cell Phone # _____

☐ OK to Phone ☐ OK to Text ☐ OK to Leave Message

Home or Other Phone # _____

☐ OK to Phone ☐ OK to Leave Message

Preferred E-mail address: (Please be aware that email might not be confidential.)

_____

☐ OK to email regarding your appointment

Preferred Method of Contact:

☐ Cell Phone ☐ Home Phone ☐ E-mail ☐ Mail

☐ Other (specify) _____

Emergency Contact:

Name _____

Relationship to you _____ Phone _____

Address _____

Section A: Demographic Information

(A1) Gender:

☐ Female ☐ Male ☐ Transgender ☐ Other _____

(A2) Ethnicity: _____

☐ Prefer Not to Answer

(A3) Sexual Orientation:

☐ Bisexual ☐ Heterosexual ☐ Lesbian/Gay ☐ Questioning

☐ Other (specify) _____

(A4) Religious/Cultural Identity: _____

☐ Prefer Not to Answer

(A5) Relationship Status:

☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
☐ Other (specify) _____

If applicable, please list your current of former partner or spouse's age and occupation:

_____

If applicable, how long have you been / were you in this relationship? _____

(A6) Educational Information: (check highest degree you have earned)

☐ GED ☐ High School ☐ Associates Degree ☐ Bachelor's Degree
☐ Master's Degree ☐ Doctoral Degree

Schools Attended / Attending _____
_____

Field(s) of Study _____

(A7) Occupational Information:

Are you currently employed? ☐ Yes ☐ No
If yes, list your current occupation and employer below. If now, list your previous occupation and employer below.

Occupation _____

Employer _____

(A8) Military Service:

Are you a Veteran? ☐ Yes ☐ No

If yes, what branch of military? _____ **Time of Service:** _____

(A9) Referred to Richland Oaks Counseling by: (check all that apply)

☐ Self (see below) ☐ Friend ☐ Family Member ☐ School Hospital ☐ Clergy/Religious Leader
☐ Medical Provider ☐ Mental Health Provider

If referred by physician or mental health provider, please provide their name and contact information:

_____

If Self, how did you hear about our services?

☐ ROCC Website ☐ Other Website ☐ Internet Search ☐ Brochure ☐ Presentation/Lecture/Workshop
☐ Other (specify) _____

Section B: Health History

(B1) Physician Information: (list name, address, and phone number)

Primary Care Physician _____
_____

Psychiatrist _____
_____

Other _____

(B2) When was your last physical exam? _____

(B3) Currently, how is your physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

(B4) Have you had any serious accidents or injuries? ☐ Yes (specify below) ☐ No

If yes, please describe: _____
_____
_____
_____

(B5) Please describe any medical issues or hospitalizations you have or had: _____
_____
_____
_____

(B6) Please list any other persistent physical symptoms or health concerns (e.g., chronic pain, headaches, hypertension, etc.) _____
_____

(B7) Do you regularly take any prescribed medications, over-the-counter drugs, supplements, or alternative remedies to treat a medical condition? ☐ Yes ☐ No

Psychiatric medications? ☐ Yes ☐ No

If yes, please list any medications you are <u>currently</u> taking, the condition for which the medication is taken, and the prescribing physician (if applicable):
(e.g. Prevacid 30 mg, stomach ulcer, Family Doctor)

_____
_____
_____
_____

(B8) Are you having any problem with your sleep habits?

☐ No problems ☐ Sleeping too much ☐ Sleeping too little ☐ Poor quality of sleep ☐ Disturbing Dreams
☐ Other (please describe) _____

(B9) How many times per week do you exercise?

☐ One or less ☐ Two to four ☐ Five or more

For about how long do you exercise at a time? _____

Section B: Health History (cont.)

(B10) Are you currently having difficulty with appetite or eating habits? Check all that apply.

☐ No difficulty ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting
☐ Significant weight change (gain or loss)

Please describe the nature of your eating habits or weight change: (e.g., frequency of eating patterns, how much weight lost and time frame, etc.) _____
_____

(B11) Do you have any problems or worries about sexual functioning? Check all that apply.

☐ No concerns ☐ Lack of desire ☐ Performance problem ☐ Sexual impulsiveness
☐ Difficulty maintaining arousal ☐ Worried about sexually transmitted disease
☐ Other (specify): _____

Section C: Mental Health History

(C1) Have you received counseling services in the past?

☐ Yes (specify below) ☐ No
If yes, please explain, including when, with whom, and whether you found it helpful: _____
_____
_____
_____
_____

(C2) Are you a returning client to Richland Oaks Counseling Center?

☐ Yes (specify below) ☐ No
If yes, when approximately did you receive services and who was the mental health provider/clinician:
_____

(C3) Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere? ☐ Yes (specify below) ☐ No

If yes, please provide the mental health provider's name and phone number:
(e.g., Dr. Smith, 214-555-5555) _____

(Our license requires a release of information form to have your clinician share information with this provider.)

(C4) Have you ever been assessed for psychological or learning issues (e.g., anxiety disorder, mood disorder, learning disorder, post-traumatic stress disorder, eating disorder, personality disorder, etc.) by a therapist, school counselor, or other provider? ☐ Yes (specify below) ☐ No

If yes, please explain, including when, by whom, and the findings/diagnosis: _____
_____
_____
_____

(C5) Have you been prescribed psychiatric medication in the <u>past</u>?

☐ Yes (specify below) ☐ No

If yes, please list what medications, dosage, and when taken:
(e.g., Prozac, 20 mg, 2012-2014) _____
_____
_____

Were the medications helpful? ☐ Yes ☐ No

Section C: Mental Health History (cont.)

(C6) Have you ever been hospitalized for psychiatric reasons?

☐ Yes (specify below) ☐ No

If yes, please specify reason for past hospitalization (check all that apply):

☐ **Psychological problems** ☐ **Suicidal thoughts/attempt**
☐ **Dangerousness to others** ☐ **Drug / Alcohol**
☐ **Other (specify)** _____

Was the hospitalization helpful? ☐ Yes ☐ No

Section D: Family and Social Information

(D1) Please list the members of your family (e.g., parents, siblings, relatives with whom you are close; *list children in Question D2*):
Name, Relationship to you, Living or Deceased, Age (or age at time of death), Occupation
(e.g., Bob, father, living, 58, accountant)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(D2) Do you have children? ☐ Yes (specify below) ☐ No

If yes, please list name, age, and gender of children (indicate if step, foster, or adopted child):
Name, Gender, Living or Deceased, Age/Grade, Biological/step/foster/adopted child
(e.g., Tommy, male, living, 9, 3rd grade, biological)

_____
_____
_____
_____
_____
_____

If yes, do you have full custody of your children? ☐ Yes ☐ No (specify below)
If no, describe the custody arrangement _____
_____

(D3) Is there a family history of mental illness, substance abuse, or learning difficulties?

☐ Yes (specify below) ☐ No

If yes, please provide a brief explanation: _____
_____
_____
_____

(D4) Besides family members, approximately how many people can you count on right now for friendship and emotional support? _____
_____

Section E: Presenting Concerns

(E1) Briefly describe what brings you to Richland Oaks Counseling Center: _____

_____
_____
_____
_____
_____

(E1 cont.) Is there any additional information about you (e.g., current difficulties, special circumstances or challenges within your family, relationships, educational or work environment) that would be helpful for us to know?

_____
_____
_____
_____
_____
_____

(E2) Approximately how long have these concerns been bothering you?

☐ A couple days ☐ A week ☐ A month ☐ Several months ☐ A year
☐ Several years ☐ Most of my life

(E3) How much do these concerns interfere with your:

Daily Routine:	**Very little : 1**	☐	**2**	☐	**3**	☐	**4**	☐	**5** ☐ **:Severe**
Emotional Well-Being:	**Very little : 1**	☐	**2**	☐	**3**	☐	**4**	☐	**5** ☐ **:Severe**
Relationships/Activities:	**Very little : 1**	☐	**2**	☐	**3**	☐	**4**	☐	**5** ☐ **:Severe**
Work / School:	**Very little : 1**	☐	**2**	☐	**3**	☐	**4**	☐	**5** ☐ **:Severe**

Thank you for completing the Intake Questionnaire.

Credit Card Authorization Form For Ongoing Therapy Sessions

PLEASE PRINT OUT AND COMPLETE THIS AUTHORIZATION AND RETURN TO US.
All information will remain confidential.

I, _____, give Richland Oaks Counseling Center permission to charge the following credit card, debit card, flexible spending card, or health savings account for the following reasons:

- Counseling Sessions
- Report/Paperwork Requests
- Records Requests
- Late Cancellations/No Show
- Group Sessions

Name on card:_____

Card Number: _____ Exp. Date: _____

Billing Zip Code: _____ Security Code: _____

Please initial the following:

_____ I understand that this release is limited to what I have agreed to above. If I would like to change the card information in the future, I will need to alert my counselor.

_____ I understand that should an account become overdrawn, I am responsible for any incurred fees.

_____ I understand that all credit cards are subject to a $3 convenience fee. I understand that this fee will be applied to each transaction on my card.

** If, for any reason, multiple "charges" are processed as one single transaction – e.g., accrued charges/past due balances, multiple family members paying for individual sessions in a lump sum payment – one (1) $3 convenience fee would be applied for the transaction.*

_____ I agree that I will pay for services in accordance with the issuing bank cardholder agreement.

_____ I understand that this release is valid when I sign it, and that I may withdraw my consent to this release at any time, either verbally or in writing.

Card holder: Print Name, Sign, and Date below:

Printed Name: _____

Signature: _____ Date: _____