JEAN DIXON

Psychotherapy, Counseling, Groups and Coaching

LPC-S, CGP
Licensed Professional Counselor-Supervisor
Certified Group Psychotherapist

INTAKE FORM

Name: _____ Date of Birth: _____

Address: _____ City, **Zip** Code: _____

Phone #: _____
Do I have your permission to leave a message? Yes No

Email Address: _____
Do I have your permission to leave a message via email? Yes No

Name of person responsible for the bill: _____

Your Occupation: _____

Name of Company for which you work? _____
School in which you attend?

Please take your time answering the following questions and please be specific.

Describe your experience with psychotherapy. Have you ever been involved in psychotherapy? If so, please list the names and dates and briefly describe positive and/or negative aspects of your experience.

_____
_____
_____
_____
_____

281.520.0707

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The Woodlands, TX 77380

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2060 N. Loop West, Ste. 205
Houston, TX 77018

Background:

Level of Education: _____

Religious/Spiritual Orientation: _____

Gender Orientation: Female Male

Sexual Orientation: Female Male Gay Lesbian
Bisexual Asexual

Current Marital Status: Single In-Relationship Married Co-Habitating
Widowed

Divorced: Yes No # of previous marriages: _____

# of Children: _____ Ages of Children: _____

Are your children living with you? Yes No
If not, Please explain:

_____
_____
_____

# of Pregnancies: _____ # of Incomplete Pregnancies: _____

Who were you raised by?

_____
_____
_____

Briefly describe your childhood. (e.g., divorces/ # of siblings/where you grew up/caregiver occupation(s):

_____
_____
_____
_____
_____

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List any neglect and/or emotional, verbal, sexual and/or physical abuse you may have experienced:

Have you **EVER** been diagnosed with an emotional, mental, behavioral, or substance use disorder? If so, briefly describe. (e.g., who, when and for what reason)

Please provide any emotional, mental, behavioral or substance use disorder diagnosed in your family.

Please provide any history of hospitalizations, major procedures, treatments, major accidents or head injuries you have experienced (e.g., dates, reasons).

Please describe any trauma you feel you have experienced (e.g. dates, situations)

Briefly describe your goals for therapy? (e.g., what do you hope or expect to accomplish, learn, attain by participating in therapy)?

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What do you most want to change about your-self/life?

Upon completion of our work together, how would you know therapy was successful? How do you imagine your life being different as a result of working together?

Current Health Related Questions:

Do you believe you have a problem with any substance, behavior or activity (e.g., illegal drugs, alcohol, prescription medications, gambling, food, exercise, people, shopping, sex, etc.)?
Please describe:

Do you use tobacco products? If so, how often and amount?

Please provide any current medications you are taking and the reasons for taking them:

Describe your eating habits:

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Describe your exercise habits:

Other Important Information:

Describe your hobbies and other interests:

Describe your family/social life:

How did you find out about me and my practice?

Friend Family Member Colleague Psychology Today Website
Jean Dixon LPC Website other Internet Sight Another Clinician
Other _____

If you were referred, do you give me permission to contact the referral? Yes No

Note: Information will be kept confidential and your name will not be used. I will only acknowledge to the referral person that I have received a referral from them and state appreciation.

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Contract between Client/Guardian of Client and Jean T. Dixon, LPC (1 of 4)

Please read carefully. You will be given a copy for your records as you will be expected to adhere to the terms contained within this contract.

Special Circumstances and Questions:

**I do not work directly with obtaining disability income. I also do not work directly with insurance companies. If you request a letter, I will provide this to you for a fee of $20.00 per letter per incident and it is your responsibility to send it to the person of interest. If you request any additional documentation (e.g. summary of treatment) the fee will be $75.00
**I do not provide a "copy" of your session notes. Instead, for confidentiality/ privacy protection of rights and safety reasons, I only provide appropriate summary notes. These notes will NOT be revealed to anyone without your written consent.
**I do not provide therapy via email and/or text messages, since these are not secure in terms of privacy and confidentiality. These forms of communication will only be used for making and/or rescheduling a session or if running late for your session. These are not forms of communication in which to consult with me or to terminate therapy. Please use a phone or, ideally, do so in session. In addition, these forms of communication will only be used upon attaining your written consent.
**Child care is not provided or offered within my practice. Please do not leave children (under the age of 14) unattended in the reception area.

_____
Initials

Legal Proceedings

I do not perform court consultations or serve as an expert witness in court cases involving child custody, divorce or criminal or civil actions. If I believe that it is necessary to disclose information to protect against a risk of serious harm being inflicted upon yourself, another person, or to the community, I may be required to take protective action. Depending on the situation, these actions may include initiating the process of hospitalization, and/or contacting the police. If such a situation arises, I will make every effort to fully disclose all procedures with you before taking any action and will limit my disclosure as necessary. ***(please see Informed Consent form for more details)***

_____
Initials

Scheduling:

I will make every effort to schedule your sessions at times that are convenient for you. If you need to cancel, **I REQUIRE a 24 hour notice prior to your scheduled session.** Failure to do so, except for certain emergencies, will result in the full charge of the missed session. IIf you have extenuating circumstances, I ask that you discuss this with me in the first session to avoid miscommunication.

_____
Initials

No Show Policy and Fee:

Please note that ONE permit of a late cancellation or failed notification is allowed. Thereafter, If you do not show for a scheduled session, you will be charged the full fee. I also require a credit card number and information for "no show" coverage. You are responsible for remembering your session. I will not send reminders. If I fail to show for a scheduled session (e.g. "double book"), your next session will be free of charge.

_____
Initials

Fees:

Payment for therapy will be required at the end of every session, and a full hourly charge will apply if you arrive late.
A reduced fee is negotiable upon request.
Longer sessions are pro-rated per 15 minutes.
In situations in which additional support between therapy sessions is considered to be beneficial, a negotiated rate will be applied accordingly.
I prefer cash or check, but all forms of payment (cash, check, credit card) are accepted.
Return checks will incur an additional $50 charge.
If a check is returned or a credit card is denied, cash will be the only payment accepted.
Please have your check written out ahead of time so as to not delay the start of the next person's session.
I accept (prefer cash and check) credit cards, debit cards, health savings account.
If you need to defer payment or require a payment plan, please discuss this with me prior to your scheduled session.
Hourly rates will apply should you request a copy of your counseling records. You will also be required to sign a "Release of Information" form.
Phone consultations lasting more than 15 minutes will be charged at an hourly rate per 15 minute increments.

The rate of $ _____._____ per session has been contracted between Jean T. Dixon LPC (psychotherapist) and _____ (client) on _____ (date). This rate can be renegotiated at any time and subject to change.

_____
Initials

If I am out of the office for an extended period of time, you will be given the contact information for another licensed psychotherapist to contact in case of emergencies. At times when you cannot reach another therapist, you are advised to go to your nearest emergency room or call 911.

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Confidentiality:

Matters shared in counseling sessions will not be discussed to anyone without your written permission. However, there are exceptions:
** I reserve the right to discuss cases with other professionals within the field for consultation purposes. However, I do not reveal names or other information that might reveal any identity.
** Therapists are legally required to report suspected abuse, neglect, or exploitation of a child, an elderly person(s) or disabled person(s) to the appropriate authority.
** Therapists have a legal and ethical obligation to warn appropriate authorities, family members, etc. when a client is seriously considering harming him/herself or others.
** Regarding legal and clinical consultation situations.
** A client initiates a malpractice lawsuit. If a client files a complaint or lawsuit against Jean T. Dixon, LPC, I may disclose relevant information regarding that client in order to defend myself.
** A court ordered judge orders a release of information.
** A client requests a release of information
** If a client discloses a past sexual abuse by a mental health provider, I am obliged to report this to the proper authorities and licensing entities.

_____
Initials

Termination:

I support all termination from therapy for whatever reasons. When you are ready to leave, I would like to help you end therapy well. The length of time to address termination is determined on an individual basis. To be considered active, all clients are asked to be in therapy a minimum of once a month. Termination is best when given notice as it offers a positive ending. In the last sessions, we will begin to focus on reviewing the course of our work together and saying goodbye. We will talk about how far you have come in accomplishing the goals you stated at the beginning of our work, what you have attained from therapy and what may be recommended as you end therapy. Ending in this manner allows you to reflect and express your experience with psychotherapy. By initializing here, you agree to participate in terminating in this manner.
Please note that I do not acknowledge termination by means of text, or email.

_____
Initials

Client Rights Regarding Privacy and HIPPA

HIPPA requires that you are given a Notice of Privacy Practices for use and disclosure of Personal Health Information for treatment, payment and health care professionals. The Notice which you have been given along with this explains have been given along with this explains HIPPA and its applications to your personal health is information given in greater detail. The law requires your signature acknowledging that you have been provided this information.
HIPPA provides you with general or expanded rights with regard to your Clinical Records and Disclosures of Protected Health Information. These rights include requesting that amendments be made to your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information

disclosures that you have neither consented to nor authorized; determining that location to which protected information disclosures are sent; having any complaints you make about the policies and procedures recorded in your records and the right to a paper copy of these privacy policies and procedures.

_____
Initials

Please list Emergency Contact:

_____ _____
Name Contact Phone Number

_____ _____
(Client Signature) (Date)

_____ _____
(Client Parent/Guardian Signature) (Date)

_____ _____
(Psychotherapist's Signature) (Date)

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