Mary Beth Cooke, MA, LMFT, LPC
903 Forest Street
Georgetown, TX 78626 512.966.6860

NEW CLIENT INFORMATION

Name: ____ DOB: ___/___/____ Age: __________________

Home Phone:____________________ Cell:____________________ Work:___________________

Do **NOT** leave a message on my ☐ Home ☐Cell ☐ Work number

Residential Address: _________________________________ City: _________________ Zip: ________

Okay to send mail to this address: Yes No Email address: ______________________________

Employer: ___________________________________ Position/Type of Work: _____________________

Emergency Contact: __________________________*Relationship:*________________*Phone:*__________

Name: ____ DOB: ___/___/____ Age: __________________

Home Phone:____________________ Cell:____________________ Work:___________________

Do **NOT** leave a message on my ☐ Home ☐ Cell ☐ Work number

Residential Address (if different from above): __________________________ City:_____ Zip: ________

Okay to send mail to this address? Yes No Email address: _________________________________

Employer: ___________________________________ Position/Type of Work: _____________________

*Emergency Contact:*___________________________*Relationship:*________________*Phone:*__________

Financial Responsibility—*If you will be using insurance benefits, please complete this section:*

Name of Insured: _______________________________Date of Birth: ___/_____/____

Insurance Carrier: ___________________ Policy/ ID#: _______________ Social Security#:____________

Who were you referred by?____

May I have permission to thank that person? YES NO

Insurance Authorization: I authorize release of information, including copies of medical records to my insurance carrier, managed care company, clinical/case manager, primary care physician as needed to fulfill insurance requirements for processing my claims or as needed for treatment planning and management required by my insurance carrier. **Assignment of Benefits**: I authorize payment of insurance benefits for services rendered to Mary Beth Cooke, MA, LMFT, LPC

Financial Responsibility: I understand that if my insurance company should deny payment for any reason, I will be responsible for any outstanding financial debt associated with therapy services.

Client: ____ Date: ________________________

Client: ____ Date:__________________________

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Office Policies and Informed Consent to Treat

This document contains important information about my professional services and business practices. The purpose is to help you make an informed decision about participating in treatment. I ask you to read this carefully and discuss with me any questions that you may have.

About the Therapy Process

It is important for you to know that therapy has both benefits and risks. Therapy often requires recalling unpleasant events and struggling with troubling issues. Thus, some people experience feelings of discomfort or distress. Although there are no guarantees about the outcomes of therapy, couples often report significant reductions in feelings of distress, satisfactory resolution of specific problems and an improvement in relationships and overall quality of life. I use an integrative approach which combines aspects of evidenced-based therapies such as Cognitive Behavioral, Solution-Focused, Family Systems, and Emotionally-Focused Therapy.

Specifics About My Practice

I am a private practitioner and hold no formal or legal association to the other practitioners providing behavioral health services in any other city. I am licensed with the State of Texas, Board of Examiners of Licensed Marriage and Family Counselors, to practice independently as a Licensed Marriage and Family Therapist. I am also fully licensed with the State of Texas, Board of Examiners of Licensed Professional Counselors. I have an MA degree in Community Counseling from the University of Mary Hardin-Baylor, accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) with Level 1 and 2 training in Eye Movement Desensitazation and Reprocessing (EMDR) from the EMDR International Assoociation. I am a Clinical Fellow of the American Association of Marriage and Family Therapists and a Professional Member of the American Counseling Association. My license is registered under my formal name: Mary Elizabeth Cooke.

Cancellation Policy

A 24 hour notice is required for changes in appointments. Late cancellations and no-shows incur a **fee of $75.00**. This fee is not reimbursable by any insurance company and will be billed to the card on file on the day of the no show/late cancel. ________________ ***(please initial)***

Client Rights

1. You have the right to decide to end our psychotherapy work at any time without prejudice. If you wish, I will provide you with the names of other qualified therapists.

2. You have the right to ask any questions about procedures used during therapy. If you wish, I will explain my usual method of psychotherapy practices with you.

3. You have the right to refuse the use of any therapeutic technique. I will inform you if I intend to use any unusual procedures and explain any risks involved.

4. You have the right to learn about alternative methods of treatment. I will discuss these with you during our work together

________________ ***(please initial)***

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Litigation Limitation:

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that if there are legal proceedings (such as divorce and custody disputes), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon. ________________ ***(please initial)***

Payment and Fees:

- Payment is due at the beginning of each session (cash, check or debit/credit card). Returned checks incur a fee of $35.00 ________ ***(please initial)***
- For couples: My standard fee is $150 per 60 minute session, $185 for 75 minutes, $225 for 90 minute session. _________ ***(please initial)***
- For individuals: My standard fee is $100 per 45 minute session, $125 for 60 minutes, $150 for 75 minutes, $175 for 90 minute session. _________ ***(please initial***
- Client phone calls are free for the first 10 minutes and are then charged at the standard rates above. All other phone calls requested by the client (i.e. consultation with a psychiatrist, physician, school, etc) are charged at the above rates. Fees for phone calls will be pro-rated. ____________ ***(please initial)***
- All other services requested by client (writing letters, filling out forms, report writing, etc) will be billed at standard hourly rates. __________ ***(please initial)***
- My fee for work legal-related work (i.e. attorney calls, writing reports, testimony preparation & court appearances) will be billed at $250.00/hr plus travel fees ______________***(please initial)***
- The fee for copies of client records is $20.00.

Therapist Availability & Emergency Procedures:

- You may leave a message for me at any time on my confidential voicemail at: **(512)966-6860.** I check messages frequently throughout the day and will return your call as soon as I am able. On weekends and holidays, I check my messages less frequently and may only respond to urgent calls. Non-urgent phone calls are generally returned within 24 hours. If I haven't returned your call within 24 hours, please call again.
- **My practice does NOT have the capacity to respond to counseling emergencies. True emergencies should be directed to 911 or to the local hotlines**
- Vacation: I will inform you in advance of my vacation schedule. I will arrange for coverage by another therapist when I am out of the office for vacation or business.
- Email is for **non-emergencies only.** It may be used for appointment changes and non-clinical questions. I check emails often, but if you are canceling an appointment with less than 24 hours notice, please call the number listed above. My email address is marybeth@marybethcooke.com.

________________ ***(please initial)***

I give Mary Beth Cooke, MA, LMFT, LPC permission to confirm sessions by email to the email listed on this New Client Form YES NO

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CONFIDENTIALITY:
In most cases (see "Exceptions to Confidentiality" below) communications between client and therapist will be held in strict confidence - unless you provide your therapist written permission to release information about your treatment. If you participate in couples or family therapy, the therapist will not disclose confidential information about treatment to a third party (other than to a third-party payer) unless all treatment participants (18 or older) provide written authorization to release such information.

Exceptions to Confidentiality
Therapists are legally-mandated to report all known or suspected instances of child abuse, dependent adult abuse and elder abuse to the appropriate authorities. Therapists are also required to notify the police as well as intended victim if it is determined that a client presents a serious danger of physical violence to another person. A therapist may break confidentiality when she believes a client is likely to be dangerous to him or herself.

Consultation: I consult regularly with other professionals regarding my clients; however, my client's identity remains completely anonymous, and confidentiality is fully maintained.

In my absence: At times, I may need to reveal your name and phone number to particular therapists covering my practice in my absence.

E - Mails, Cell Phones, Computers and Faxes:
Individuals may choose to contact me via email, fax or cell phone. In doing so, they agree to the understanding that email, fax and cell phone communication are not guaranteed confidential methods of communication, and they are, by choice, relinquishing their rights of confidentiality.

________________ ***(please initial)***

Authorization for Treatment:

Your signature below indicates that you have had the opportunity to read and review the information in this three-page document, that questions regarding your care have been satisfactorily answered and that you have received a copy of this informed consent.

I authorize evaluation and treatment from Mary Beth Cooke, MA, LMFT, LPC and I agree to pay fees for such treatment.

Client signature ______________________________________Date_______________________

Client signature ______________________________________Date_______________________

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INTAKE QUESTIONNAIRE (*EACH PERSON NEEDS TO COMPLETE THIS FORM)*

NAME: ____

Reflecting on the last 6 months, please circle all that apply:	
Frequently sad or depressed	Feeling restless or keyed up
Overwhelming worries	Restless unsatisfying sleep
Difficulty falling asleep or staying asleep	Muscle tension
Unable to concentrate	
Irritable and/or short temper	Mood Swings
Significant change in weight	Decreased need for sleep (only need 3-4 hrs)
Low energy level/fatigue	Feel more talkative than usual
Feeling excessive guilt or shame	Excessive spending/shopping
Unable to relax	Excessive gambling
Lack of appetite/increased appetite	Easily distracted by unimportant things
Loss of interest in activities/hobbies	Take too many risks
Feeling hopeless	
Feeling worthless	
Difficulty motivating	Troubling thoughts about the past
Withdrawn/isolating self	Nightmares
Cry easily/often	Exaggerated startle response
Difficulty making a decision	Too neat and orderly
Difficulty finishing tasks	Repeating certain behaviors over and over
Thoughts to hurt self	Easily upset or angered
Attempts to harm yourself	Feeling different from most people
Thoughts to hurt others	Shy around others
Threats to hurt others	Increasingly forgetful
	Strong fears
Feeling ill/sick	Difficulty with work or school

Have you been in therapy before? ☐ Yes ☐ No   If yes, please state when and where:
____
____

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Medical History

Are you currently being treated for any medical problems? ☐ Yes ☐ No
Please list medications you are currently taking:

Dosage	Type	For (i.e. depression)	Prescribed by

Do you smoke cigarettes (cigars, chew)? ☐ Yes ☐ No #______per day
How much alcohol do you drink? #_________per day _________# per week
Do you use illicit drugs? ☐ Yes ☐ No
Have you ever tried to cut down or stop using alcohol or drugs? ☐ Yes ☐ No
Has anyone ever asked you to cut down on your drinking? ☐ Yes ☐ No
Have you ever been hospitalized for any emotional/ mental health condition? ☐Yes☐ No

Have you experienced or witnessed a traumatic event? (*parental violence, domestic violence, community violence, natural disaster, injury or death to a loved one*, etc) ☐ Yes ☐ No
Do you have a history of domestic violence? ☐ Yes ☐ No
Do you have a history of verbal, emotional or physical abuse? ☐ Yes ☐ No
Do you have a history of sexual abuse or sexual assault? ☐ Yes ☐ No

FAMILY HISTORY

Have you or anyone in your family (i.e. siblings, grandparents, etc) experienced any of the following? If yes, please note their relationship to you.

Has anyone experienced:	**Family Member(s)**
Anxiety	
Depression	
Bipolar disorder	
Learning disorders (ADHD, dyslexia, etc).	
Illicit drug use/Alcohol abuse	
Anger Issues	
Eating Disorder	
Phobias	
Hospitalization for Mental Health Condition	
Attempted or completed suicide	

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NOTICE OF PRIVACY PRACTICES

Please Read Carefully

THIS NOTICE PROVIDES YOU WITH INFORMATION ABOUT HOW YOUR PROTECTED HEALTH INFORMATION (PHI) MAY BE USED AND DISCLOSED BY THIS PROVIDER, AS WELL AS YOUR RIGHTS REGARDING YOUR PHI. YOUR PHI INCLUDES INFORMATION WHICH RELATES TO YOUR PAST, PRESENT OR FUTURE HEALTH, TREATMENT OR PAYMENT FOR HEALTH CARE SERVICES.

1. LEGAL DUTY TO SAFEGUARD YOUR *PROTECTED HEALTH INFORMATION* (PHI).

The Health Insurance Portability and Accountability Act (HIPPA) requires me to:

- Keep your medical information private.
- Give you this notice describing my legal duties, privacy practices and your rights regarding your medical information.
- Follow the terms of the current notice.

I have the right to change my privacy practices and terms of this notice at any time, provided that the changes are permitted by law.

Notice of Change to Privacy Practices: Before an important change is made in my privacy practices, I will change this notice and make the new notice available upon request.

2. USE AND DISCLOSURE OF YOUR PHI

The following section describes different ways that your PHI may be used or disclosed. For some of these uses or disclosures, I will need your prior authorization; for others, I do not. I will not disclose your PHI for any purpose not listed below without your specific written authorization. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization).

Uses and Disclosures Relating to Treatment, Payment or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

- ***FOR TREATMENT:*** I may disclose your PHI to other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist. I may disclose your PHI to your psychiatrist in order to coordinate your care.
- ***FOR PAYMENT:*** I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. I may also provide PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
- ***FOR HEALTH CARE OPERATIONS:*** I may use and disclose your PHI to operate my practice.
- ***ADDITIONAL USES AND DISCLOSURES that do not require consent: When disclosure is required by federal, state or local law, judicial or administrative proceedings or law enforcement.*** For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
- ***For public health activities***. As required by law, I may disclose your PHI to public health or legal authorities charged with preventing, controlling or responding to disease, injury, disability and/or death including child abuse and neglect.
- ***For health oversight activities***. For example, I may have to report information to assist the government when it conducts an investigation or inspection of a health provider or organization.
- ***To avoid harm***. To prevent a serous threat to your own health or safety or the health or safety of others.
- ***For workers' compensation purpose***. I may provide PHI in order to comply with workers' compensation laws.

- ***Appointment reminders and health related benefits or services.*** I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

3. YOUR INDIVIDUAL RIGHTS REGARDING YOUR PHI

- ***The Right to Choose How I Send PHI to You***. You have the right to ask that I send information to you at an alternate address or by alternate means (for example, e-mail instead of regular mail). I will agree to your request so long as it is reasonable for me to do so.
- ***The Right to See and Get Copies of Your PHI.*** In most cases you have the right to look at or get copies of your PHI, but you must make the request in writing. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI l collected in connection with a legal proceeding. I will respond to you within 10 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more that $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.
- **The *Right to Get a List of the Disclosures I have Made***. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to such as those named for treatment, payment, or health care operations directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel or disclosures made before June 1, 2008.
- ***The right to ask that I limit how I use and disclose your PHI***. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am " legally" required or allowed to make.
- ***The Right to Correct or Update Your PHI.*** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 30 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (a) Correct and complete, (b) not created by me, (c) not allowed to be disclosed, and/or (d) not a part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it and tell others that need to know about the change to your PHI.

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES. If you have any questions about this notice or any complaints about my privacy practices or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services please contact your provider, Denan Burke. There will not be any retaliation for filing a complaint.

EFFECTIVE DATE OF THIS NOTICE. This notice went into effect on June 1, 2008

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**** Please sign the attached consent page. You may keep these two pages for your records.****

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NOTICE OF PRIVACY PRACTICES SIGNATURE PAGE
CONSENT TO USE & DISCLOSE
PROTECTED HEALTH INFORMATION (PHI)

This form documents your consent with HIPAA laws regarding Protected Health Information (PHI) about your care. This information is necessary to provide treatment, to arrange payment for services, and for business activities ("Health Care Operations").

By signing this form, you agree to allow Mary Beth Cooke, MA, LMFT, LPC to use this information and share it with others for treatment-related purposes. If this Notice changes, you will be notified at our next session. You may revoke your consent at any time after signing.

I hereby acknowledge that I have reviewed and received a copy of the "Notice of Privacy Practices" for the psychotherapy practice of Mary Beth Cooke, LMFT, LPC

Print Name: __________________________ Signature: ___________________________

Print Name: __________________________ Signature: ___________________________

Date: _______________________________________

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Credit Card Authorization Form

****It is the policy of this office to keep a debit/credit card on file. You may pay by cash or check, but a card must still be kept on file.****

Name on Card:

____

I authorize Mary Beth Cooke, MA, LMFT, LPC to charge my credit/debit card for professional services as follows:

Initial

_______ **All visits for which payment was not made at time of visit (this includes fee for service, deductibles and co-pays).**

_______ **To charge my card for the balance of fees not paid by my insurance company within 90 days.**

_______ **To charge my card $75.00 for each no-show or late cancellation (less than 24 hours notice).**

Type of Card: ☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX

Credit Card Number _______ - _______ - _______ - _______   CVV Number _________
3-digit number on the **back** of the card

Expiration Date _____________

Card Holder's Billing Address for Credit Card Statements:

____
Street   *City*   *State*   *Zip*

Card Holder Signature _____________________________________, Date ____ /_____ /____

Charges will appear on your credit card statement as ___________________________________