Cyndee Elwood, LMFT, MAC

413 W. Bethel Road, Suite #100
Coppell, Texas 75019
972-393-1596 Ext. 64

Welcome to Coppell Counseling Center!

Thank you for making your first appointment. I look forward to working with you.
I would ask that you review the following documents and sign where it is indicated. Please print and bring the documents so indicated with you to your first appointment.
When you arrive at Coppell Counseling Center, please press the button on the light panel next to my name, to the left of the reception window. I will be out shortly to greet you.

Respectfully,

Cyndee Elwood, LMFT, MAC

NOTICE OF PRIVACY PRACTICES

PLEASE KEEP THIS FORM

The privacy of your health information is important to me. I will maintain the privacy of your health information and I will not disclose your information to others unless you tell me to do so, or unless the law authorizes or requires me to do so. **You need to know about these rules of confidentiality now, so that you don't tell me something as a "secret" that I cannot keep secret.**

A federal law commonly known as **HIPAA** requires that I take additional steps to keep you informed about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to provide you with the attached **Notice of Privacy/Confidentiality Practices** and to request that you sign the attached written acknowledgement that you received a copy of the Notice. The Notice describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information I maintain about you and a brief description of how you may exercise these rights.

If you have any questions about this Notice, please contact: **Cyndee Elwood at 972-393-1596 Ext. 64.**

NOTICE OF PRIVACY PRACTICES and CONFIDENTIALITY IN THERAPY

Please Keep this Copy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information listed in Section II G of this notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures without Your Written Authorization

I may use and disclose PHI without your written authorization, as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. **Treatment:** I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment to consult about your care.

2. **Payment:** I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment or Employee Assistance Program services.

3. **Health Care Operations:** I may use and disclose PHI in connection with our health care operations, Employee Assistance Programs, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. **Required or Permitted by Law:** I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

B. Uses and Disclosures Requiring Your Written Authorization

1. Psychotherapy Notes: Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and may not be used or disclosed without your written authorization, except when legally requested.

2. Marketing C

3. Communications: I will not use your health information for marketing communications without your written authorization.

4. Other Uses and Disclosures: Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy: You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you.

B. Right to Alternative Communications: You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions: You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. I am not required to agree to any such restriction you may request.

D. Right to Accounting Disclosures: Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. Right to Request Amendment: You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

F. Right to Obtain Notice: You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.

G. Questions and Complaints: If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact the **Privacy Officer, Cyndee Elwood, LMFT, MAC** at 413 W. Bethel Rd. Ste #100, Coppell, TX 75019, (972)393-1596 Ext. 64. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the Director or with me.

III EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date: This Notice is effective on April 14, 2003.

B. Changes to this Notice: I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the waiting area of my office. You may also obtain any revised notice by contacting the Privacy Officer.

Practice Policies

Cyndee Elwood, LMFT, MAC

Welcome New Clients!

I am an independent, licensed professional practitioner of counseling at the location of Coppell Counseling Center. I will work with you to provide you individualized service which is appropriate for your needs. I am licensed as a Licensed Marriage and Family Therapist (LMFT) in the state of Texas and California and certified as a Masters Addiction Counselor nationwide. My under graduate degree was completed at the University of Wisconsin-Eau Claire in 1976. My graduate studies were completed at United States International University (now Alliant University) in Irvine, California. I have actively participated in leadership positions in my professional organizations and sat on the Board of a Child Abuse Prevention Counsel in Rancho Mirage, California. I have also taught, supervised and mentored Marriage and Family Therapy Interns for the past 8 years. I actively participate in continuing education experiences to update and practice my skills. I have been in private practice since 1999. I would be happy to discuss my professional experience or credentials with you at your request.

Practice Policies

Clients are seen by appointment only. Sessions will usually last 50 minutes, unless more time is agreed upon in advance. If you wish to change your appointment or cancel, please give at least 24 hours' notice. Allowances will be made for emergencies, but be mindful that you ***may be charged full fee for missed appointments.*** *The* ***initial session fee is $150.00*** *an* ***each session will be $125.00,*** *unless we have agreed upon insurance coverage or have made other arrangements. You are responsible for any authorization, fees or co-pays at each visit. I accept MasterCard and Visa, checks, and cash for payment. I will provide you a receipt for third party reimbursement,* ***if requested.***

I may be reached 24 hours a day at ***(972) 393-1596 Ext. 64*** *and through voice mail. I generally see clients Monday through Friday though there can be other arrangements made for other times. I will return calls as soon as it is feasible. I will not interrupt sessions to return calls. At times, there will be another therapist "on call" to cover my absence. If you have any complaints about my service to you, I invite you to discuss them with me at once. This process may enhance the therapeutic experience and your progress. If you would like to make a formal complaint, please contact:*

Texas State Board of Examiners of Marriage and Family Therapists
Complaints Management and Investigation Section
P.O. Box 141369
Austin, Texas 78714-1369
Email: mft@dsha.state.tx.us Telephone: (512) 834-6628 Fax: (512) 834-6677

National Association of Forensic Counselors
P.O. Box 8827
Fort Wayne, Indiana 46898-8827

What to Expect From Treatment

*What we discuss in counseling is generally confidential. You will read in another, more detailed information form about privacy practices and confidentiality in counseling relationships. Counseling is a process of self-examination, emotional awareness and growth. You may choose to make changes in your attitudes, perceptions and behavior, as you progress. There is no guarantee that counseling will "**cure**" you. Counseling about issues of concern will require different amounts of time to address and resolve. Research has shown that psychotherapy may contribute to productivity, enhance self-respect, and improve communication in all kinds of relationships.*

This process may be exciting, energizing, exhausting, or even painful. Emotional healing may become personally enriching, encouraging you to face conflict in relationships and learn new coping styles. I will do everything possible to provide a positive counseling experience for you. When indicated, you or your family may be referred for additional services; such as a physical examination by your physician, medication evaluation, or other types of therapy or support groups. We will discuss those options during your sessions. If I cannot provide the professional care you need or you would like to consult another counselor, I will be happy to refer you to someone who may help you with your concerns.

Upon my death or incapacitation, your records will be stored with Ms. Janie Garrett, LCSW, here at the same office address. I generally keep your records for 5 years past the date of our last appointment. All questions about your counseling experience will be answered with respect to your concerns.

Thank you for the opportunity to be of service to your or your family!

Please keep this form for reference!

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Client Bill of Rights

You have the right to:

-Receive respectful treatment that will be helpful to you

-Have a safe treatment setting, free from sexual, physical, and emotional abuse

-Report immoral and illegal behavior by a therapist

-Ask for and receive information about the therapist's qualifications, including his or her license, education, training, experience, membership in professional groups, special areas of practice and limits on practice

-Have written information, before entering therapy, about fees, method of payment, insurance coverage, number of sessions the therapist thinks will be needed, substitute therapists and cancellation policies

-Refuse audio or video recording of sessions (but you may ask for it if you wish)

-Refuse to answer any question or give any information you choose not to answer or give

-Know if your therapist will discuss your case with others (for instance, supervisors, consultants or students)

-Ask that the therapist inform you of your progress

Please keep this form for your records!

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Limits of the Therapeutic Relationship: What Clients Should Know

Psychotherapy is a professional service I can provide to you. Because of the nature of therapy, our relationship has to be different from most relationships. It may differ in how long it lasts, in the topics we discuss, or in the goals of our relationship. It must also be limited to the relationship of therapist and client only. If we were to interact in any other ways, we would then have a "dual relationship," which would not be right and may not be legal. The different therapy professions have rules against such relationships to protect us both.

I want to explain why having a dual relationship is not a good idea. Dual relationships can set up conflicts between my own (the therapist's) interests and your (the client's) best interests, and then your interests might not be put first. In order to offer all my clients the best care, my judgment needs to be unselfish and professional.

Because I am your therapist, dual relationships like these are improper:

- □ I cannot be your supervisor, teacher, or evaluator.
- □ I cannot be a therapist to my own relatives, friends (or the relatives of friends), people I know socially, or business contacts.
- □ I cannot provide therapy to people I used to know socially, or to former business contacts.
- □ I cannot have any other kind of business relationship with you besides the therapy itself. For example, I cannot employ you, lend to or borrow from you, or trade or barter your services (things like tutoring, repairing, child care, etc) or goods for therapy.
- □ I cannot give legal, medical, financial, or any other type of professional advice.
- □ I cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client.

There are important differences between therapy and friendship. As your therapist, I cannot be your friend. Friends may see you only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may
Need to have you do what they advise.

A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change. You should also know that therapists are required to keep the identity of their client's secret. Therefore, I may ignore you when we meet in a public place, and I must decline to attend your family's gatherings if you invite me. Lastly, when our therapy is complete, I will not be able to be a friend to you like other friends. In sum, my duty as therapist is to care for you and my other clients, but only in the professional role of therapist. Please note any questions or concerns on the back of this page so we can discuss them.
Thank you!

Please keep this form for your records!

*******Please bring the remaining forms with you to the 1st appointment*******

Cyndee Elwood, LMFT, MAC

ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy/Confidentiality Practices

Practice Policies/Consent to Treatment

By my signature below I, _____, acknowledge that I read, received copies, and understand the **Notice of Privacy/Confidentiality Practices and Practice Policies** for **Cyndee Elwood, LMFT, MAC.**

I do seek and consent to take part in the treatment by the therapist named above. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop counseling with this therapist at any time. The only thing I will be responsible for is paying for services I have already received. I understand that I may lose other services or may have to deal with other problems, if I stop treatment. (For example, If my treatment has been court ordered, I will have to answer to the court).

I know I must contact the therapist to cancel at least 24 – 48 hours before the time of my appointment. If I do not cancel and do not show Up, I will be charged for that missed appointment.

I am aware that an agent with my insurance company or other third party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment and seek to collect the fees.

I understand that some forms of communication such as unencrypted internet, cell phone, telephone, and text message are not guaranteed to protect my privacy. I realize that my confidentiality can be maintained through www.therapyappointment.com and my therapy sessions.

_____ _____

Signature of client (or personal representative) **Date**

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

I, the therapist, have discussed the practice policies and issues above with the client or his/her personal representative. My observation of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist **Date**

For Office Use Only

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgment
- □ An emergency situation prevented us from obtaining acknowledgment
- □ Other (Please specify):

CYNDEE ELWOOD, LMFT, MAC
413 W. Bethel Road, Suite #100
Coppell, Texas 75019
Phone: (972) 393-1596 X 64 **www.celwood@coppellcounseling.com** **Fax: (972) 304-0400**

CLIENT INTAKE FORM

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security - -	Home Phone No. ( )

P.O. Box	City	State	ZIP Code	Cell Phone No. ( )

Occupation	Employer	Work Phone No. ( )

Referred to Provider by (Please check one box & list) ❑ Dr. _____ ❑ Insurance Plan ❑ Website
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Email Address:	Alternative Email Address:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑ No	Total Annual EAPs allowed? _____

Please Select Your Primary Insurance Provider

❑ Amerigroup ❑ Assurant ❑ Beech Street ❑ Blue Cross/Blue Sheild ❑ ChoiceCare ❑ Champus
❑ Cigna ❑ Definity Health ❑ First Health ❑ HealthSmart ❑ Humana ❑ Magellan/Aetna ❑ Medicaid
❑ Medicare ❑ MHN/MHNet ❑ PHCS ❑ PMHS ❑ Texas One Choice ❑ TriCare ❑ Unicare
❑ United Healthcare ❑ Value Options ❑ Other _____

What is the authorization number? ❑ Self Pay

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if any) Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

Cyndee Elwood, LMFT, MAC

CLIENT INTAKE FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. _____ will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

Please Complete 1 Form for Each Individual in The Couple & Bring it to Office!

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CLIENT INTAKE FORM

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security - -	Home Phone No. ( )

P.O. Box	City	State	ZIP Code	Cell Phone No. ( )

Occupation	Employer	Work Phone No. ( )

Referred to Provider by (Please check one box & list) ❑ Dr. _____ ❑ Insurance Plan ❑ Website
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Email Address:	Alternative Email Address:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑ No	Total Annual EAPs allowed? _____

Please Select Your Primary Insurance Provider

❑ Amerigroup ❑ Assurant ❑ Beech Street ❑ Blue Cross/Blue Sheild ❑ ChoiceCare ❑ Champus
❑ Cigna ❑ Definity Health ❑ First Health ❑ HealthSmart ❑ Humana ❑ Magellan/Aetna ❑ Medicaid
❑ Medicare ❑ MHN/MHNet ❑ PHCS ❑ PMHS ❑ Texas One Choice ❑ TriCare ❑ Unicare
❑ United Healthcare ❑ Value Options ❑ Other _____

What is the authorization number? ❑ Self Pay

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if any) Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

Cyndee Elwood, LMFT, MAC

CLIENT INTAKE FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. _____ will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

Please Complete 1 Form for Each Individual in The Couple & Bring it to Office!

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ADULT INFORMATION FORM

Name_____Date of Birth _____Age _____Gender:Male ___Female ___

MEDICAL HISTORY

Name of Primary Care Physician:_____
Physician's Address:_____Physician's Phone: _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor?
(Circle One) YES NO

Please sign here for either answer:_____

Date of last medical evaluation:_____ Date of next appointment:_____

Current medications being taken:
1)_____ Dosage/Freq_____ Start Date_____Purpose_____
2)_____ Dosage/Freq_____ Start Date_____Purpose_____
3)_____ Dosage/Freq _____Start Date_____ Purpose_____
4)_____ Dosage/Freq _____Start Date_____ Purpose_____

Prescribed by:_____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop? _____

Type of Drug	How much	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO
If yes, please list:

Type of Alcohol	How much	How often
_____	_____	_____
_____	_____	_____

Do you smoke cigarettes? (Circle One) YES NO
Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind? _____

Describe any important medical history, chronic ailments, or other health problems you experience:_____
_____
_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:

_____
_____
_____
_____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

_____
_____
_____
_____

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain:_____
_____
_____

What was the last year of school you completed? _____ If you did not complete high school, please explain: _____
_____

Please list schools (1) currently attending, (2) last attended, (3) graduated:
(1) School(s)_____ Year(s)_____
(2) School(s)_____ Year(s)_____
(3) School(s)_____ Year(s)_____

How would you describe your current support network? (friends, relatives, etc.): _____
_____

Please check all information which applies to your biological parents:

MOTHER	____ living	FATHER	____ living
	____ deceased		____ deceased
	____ married		____ married
	____ divorced		____ divorced
	____ remarried ____# of times		____ remarried ___# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents?
If so, whom? _____

Where do your parents live? Mother _____
Father _____

Describe your relationship with your mother while growing up_____
_____

Currently: _____
_____

Describe your relationship with your father while growing up: _____
_____

Currently: _____
_____

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any family problems which occurred while growing up relating to:
Alcohol/drug abuse:
_____
_____
_____

Sexual/physical/emotional abuse:_____
_____
_____

MARITAL HISTORY

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone
If currently married, when were you married? _____ If living w/someone, how long? _____

Please list your children:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:
____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ____aggressive ___resentful ____worthless ___tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ____helpless

Describe any other feelings you have had:_____
_____

What activities or hobbies do you participate in? _____
_____

Do you participate in regular exercise? (Circle One) YES NO Describe:_____

Describe your current working environment:_____
_____

Have you had any change in sleeping habits? (Circle One) YES NO Describe:_____
_____

Have you had any change in eating habits? (Circle One) YES NO Describe: _____
_____

Have you ever **considered suicide** in connection to your current problem? (Circle One) YES NO
If so, please give a brief description with dates:_____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO
If so, please give a brief description with dates:_____

Have you **attempted suicide** recently or in the **past**? (Circle One) YES NO

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO
If yes, please explain:_____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO
If yes, please explain:_____

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.):

_____
_____

THOUGHTS: Please check any of the following that apply to you:
_____I sometimes hear voices even though no one nearby is talking to me.
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_____I sometimes have the same thought over and over and cannot control it.
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_____I am sometimes unable to control my behavior. Please explain:_____
_____
_____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____
_____
_____
_____
_____

Please list your therapy goals:

_____
_____
_____
_____
_____

THANK YOU!

PLEASE COMPLETE 1 OF THESE FORMS FOR EACH INDIVIDUAL OF THE COUPLE & BRING THEM TO THE OFFICE FOR YOUR FIRST SESSION!

CYNDEE ELWOOD, LMFT, MAC
413 W. Bethel Road, Suite #100
Coppell, Texas 75019
Phone: 972-393-1596 Ext 64 www.celwood@coppellcounseling.com Fax: 972-304-0400

ADULT INFORMATION FORM

Name_____Date of Birth _____Age _____Gender:Male ___Female ___

MEDICAL HISTORY

Name of Primary Care Physician:_____
Physician's Address:_____Physician's Phone: _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor?
(Circle One) YES NO

Please sign here for either answer:_____

Date of last medical evaluation:_____ Date of next appointment:_____

Current medications being taken:
1)_____ Dosage/Freq_____ Start Date_____Purpose_____
2)_____ Dosage/Freq_____ Start Date_____Purpose_____
3)_____ Dosage/Freq _____ Start Date_____Purpose_____
4)_____ Dosage/Freq _____ Start Date_____Purpose_____

Prescribed by:_____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop? _____

Type of Drug	How much	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO
If yes, please list:

Type of Alcohol	How much	How often
_____	_____	_____
_____	_____	_____

Do you smoke cigarettes? (Circle One) YES NO
Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind? _____

Describe any important medical history, chronic ailments, or other health problems you experience:_____
_____
_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:

_____
_____
_____
_____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

_____
_____
_____
_____

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain:_____
_____
_____

What was the last year of school you completed? _____ If you did not complete high school, please explain: _____
_____

Please list schools (1) currently attending, (2) last attended, (3) graduated:
(1) School(s)_____ Year(s)_____
(2) School(s)_____ Year(s)_____
(3) School(s)_____ Year(s)_____

How would you describe your current support network? (friends, relatives, etc.): _____
_____

Please check all information which applies to your biological parents:

MOTHER	____ living	FATHER	____ living
	____ deceased		____ deceased
	____ married		____ married
	____ divorced		____ divorced
	____ remarried ____# of times		____ remarried ___# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents?
If so, whom? _____

Where do your parents live? Mother _____
Father _____

Describe your relationship with your mother while growing up_____
_____

Currently: _____
_____

Describe your relationship with your father while growing up: _____
_____

Currently: _____
_____

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any family problems which occurred while growing up relating to:
Alcohol/drug abuse:
_____
_____
_____

Sexual/physical/emotional abuse:_____
_____
_____

MARITAL HISTORY

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone
If currently married, when were you married? _____ If living w/someone, how long? _____

Please list your children:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:
____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ____aggressive ___resentful ____worthless ___tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ____helpless

Describe any other feelings you have had:_____
_____

What activities or hobbies do you participate in? _____
_____

Do you participate in regular exercise? (Circle One) YES NO Describe:_____

Describe your current working environment:_____
_____

Have you had any change in sleeping habits? (Circle One) YES NO Describe:_____
_____

Have you had any change in eating habits? (Circle One) YES NO Describe: _____
_____

Have you ever **considered suicide** in connection to your current problem? (Circle One) YES NO
If so, please give a brief description with dates:_____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO
If so, please give a brief description with dates:_____

Have you **attempted suicide** recently or in the **past**? (Circle One) YES NO

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THANK YOU!

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Consent to Use PHI for Treatment, Payment, and Healthcare Operations

With my consent, Cyndee Elwood may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Cyndee Elwood Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Cyndee Elwood reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Cyndee Elwood, Privacy Officer at 413 W. Bethel Road, Suite #100, Coppell, Texas, 75019.

With my consent, Cyndee Elwood may call my cell phone or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care. With my consent, Cyndee Elwood may mail to my home or other designated location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential.

With my consent, Cyndee Elwood may e-mail to me my appointment reminder cards and patient statements. I have the right to request that Cyndee Elwood restrict how it uses or discloses my PHI to carry out TPO. However, the practice is required by state statutes to agree to my requested restrictions, unless in extenuating circumstances allowed by law.

By signing this form, I consent for Cyndee Elwood to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Cyndee Elwood may decline to provide treatment to me.

Signature of Patient or Legal Guardian

_____ Date: _____

Print Name of Patient

_____

Staff Member Signature: **Please bring this form to office!**

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COUPLES THERAPY PARTICIPATION AGREEMENT

____Cyndee Elwood, LMFT_____ and _____("the Clients") have chosen to use the couples therapy to resolve their family differences. The Clients have agreed to engage (Therapist name), a (type of practitioner), to assist them with couple's therapy.

The Clients also agree to the following:

1. To provide a full and candid exchange of information between them and their therapist necessary to make a proper assessment of their relationship;
2. Be respectful during counseling sessions to improve the flow of information

The Therapist agrees to the following:

He/she will act as a neutral mental health professional and will not align with either client

The therapist's duties may involve the following:

- assisting the Clients to achieve outcomes that reflect their goals and interests and address the best interests of their relationship as well as children;
- improving the Clients' negotiation and problem-solving skills;
- increasing effective communication among family members;
- assisting the Clients in recognizing their relational strengths and weaknesses to enhance their future relationship; Testimony and Future Consulting

The Clients and the therapist agree that if the counseling terminates, the therapist not be called as a witness by either client in any future litigation between the Clients, unless both Clients and the therapist agree otherwise in writing. The Clients and the therapist further agree that, if couple's counseling terminates, the therapist may not be further consulted by either client, unless the Clients reinstitute the couples counseling process.

Dated: _____ _____
Therapist

_____ _____
Partner Partner

Please Bring this Form to Office!

Cyndee Elwood, LMFT, MAC

Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit www.therapyappointment.com to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system.

Your name: _____

Requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

Requested password: |__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

Your email address: _____

Your cell phone number: _____

Your cell phone carrier (circle one):

Alltel AT&T Boost Mobile Nextel Sprint SunCom
T-mobile Verizon VoiceStream Virgin Mobile (Other) _____

Where would you like to receive appointment reminders? (check one)

____ Via a text message on my cell phone (normal text message rates will apply)
_____ Via an email message to the address listed above
_____ Via a traditional telephone message to my home phone
_____ None of the above. I'll remember my appointments on my own.
(missed appointment fees will still apply)

Your appointment scheduling and reminders are part of your protected health information under HIPAA, so by signing this form, you are acknowledging your waiver of the right to privacy for that informatio.

Signature _____ **Date**_____

Please Bring this Form to Office!