CYPRESS
Counseling & Psychotherapy
FIND YOUR PATH

12242 Queenston Blvd
Suite F & C

Houston, Texas 77095
admin@cypresscounselors.com

CLIENT CONTACT INFORMATION SHEET

Name:

Birth Date: ____/____/____Age:_____

Gender: MALE

Social Security Number:_____

Address (Street and Number):_____
City:_____State:_____Zip:_____
Home Phone: (____) ____-_____

May We Leave a Message

- YES
- Cell/Other Phone: (____)____-_____

E-mail:
May We Email You?

- YES

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation:
Place of Employment:_____
Work Number: (____)____-_____
If needed, is it OK to call here?

- YES

Emergency Contact:

Name:_____Relationship:_____
____ ____-_____
Phone Number: ( )

Insurance Information:

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Client Intake Form

Date of first appointment:

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

Referred by:

- Medical Provider: _____
- Insurance Provider: _____
- My Website: https://cypresscounselors.com ☐
- Psychology Today ☐
- Friend/Family: _____
- Other: _____

Have you previously received any type of mental health services?

- NO

If yes, which of the following:

- Psychotherapy ☐
- Medication ☐
- Outpatient Hospitalizations ☐
- Inpatient Hospitalization ☐
- If yes, please provide:

Name of provider or facility:_____

Location:_____

Dates of treatment:_____

Reason for treatment:_____

Briefly, what brings you in today?

When did your problem first start? Within the last:

- 30 days ☐
- 6--12 months ☐
- 2 years ☐
- During adolescence ☐
- During childhood ☐

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

Are you currently experiencing overwhelming sadness, grief or depression?

- YES

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?

- NO

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced:

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

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

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Family History

Where were you born? _____

Where did you grow up? _____

-
- SUBURBS
-

Country

Please list your parents and siblings.

Name Age Relationship Where do they live now? If deceased, age and cause of death

Name	Age	Relationship	Where do they live now	If deceased, age and cause of death

Who did you live with while growing up? _____

Mother's occupation: _____

Father's occupation? _____

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

Condition	Please Select:	List Family Member
Alcohol/substance	NO	
Anxiety	NO	
Depression	NO	
Domestic Violence	NO	
Sexual Abuse	NO	
Eating Disorders	NO	
Obesity	NO	
Obsessive Compulsive Disorder	NO	
Schizophrenia	NO	
Suicide Attempts	NO	
Other Diagnosed Mental Health Conditions	NO	

Marital Status:

- Never Married ☐
- Domestic Partner ☐
- Married ☐
- Separated ☐
- Divorced -- For how long?
- Widowed: Please provide your partners name and year deceased:
- If married, how long have you been married for and what is your partners name:

  _____

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

10

Are you currently in a romantic relationship? YES

How Long? _____

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Please list any children, their names, and ages:

Name	Age	Relationship	Name of other Parent	If deceased, age and cause of death

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

Medication/Supplement	Dosage	Condition	Date Began/Stopped

Prescribing provider and contact information:
Name:_____
Specialty:_____
Facility: _____

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Phone, email, or Fax: _____

How would you rate your current physical health?

- Poor ☐
- Unsatisfactory ☐
- Satisfactory ☐
- Good ☐
- Very Good ☐

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

- Poor ☐
- Unsatisfactory ☐
- Satisfactory ☐
- Good ☐
- Very Good ☐

If you are having problems, in which phase of sleep are you experiencing issues?

- Falling asleep ☐
- Staying asleep ☐
- Awakening early ☐
- Sleep apnea ☐

Please list any other specific sleep problems you are currently experiencing:

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

Are you currently experiencing any chronic pain?

-
- YES

If yes, please describe:

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

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

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Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

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

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?

Consent for Counseling Services:

Federal and state law requires that you understand the counseling philosophy and practice of behavioral health facilities and your rights as clients or the caretakers of clients. Please read this information carefully and initial or sign where indicated. Feel free to ask questions should there be anything you do not fully understand. A full copy of this Form will be furnished for your records.

_____Initial here if you have read and understood this section.

Clinical Background and Philosophy

Cypress Counseling & Psychotherapy, PLLC provides a full range of counseling services with the purpose of supporting and promoting personal growth, positive relationships, and emotional wellbeing. We do not provide psychiatry or psychology services.

While there are no guarantees for the outcome of the counseling process, the counselor will work with you to determine counseling goals, treatment plans and techniques to help you. The counseling process is difficult; you may experience negative feelings during the process in order to bring healing and/ or resolution to the identified issues.

The counselor understands that you have a choice of whether or not you participate in the counseling process, and that you may wish to discontinue it at any time (a termination or transition session is highly recommended). For the process to work you must bear the responsibility to attend you sessions consistently and to maintain open communication with your counselor.

_____Initial here if you have read and understood this section.

Length of Counseling Therapy and Treatment

You will normally be the one who decides the length of the counseling therapy treatment. However, in most cases, we will agree on a certain number of initial sessions during your intake session to efficiently establish a counseling relationship. If we are not able to help you, because of the kind of problem you are experiencing, or because our training and skills are, in our judgment not appropriate, we will inform you of this fact and refer you to another counselor who may better meet your needs.

_____Initial here if you have read and understood this section.

- **Records**

HIPPA, state law, and standards of the mental health profession require that treatment records are kept in a documented file. These records include all aspects of individually identifiable information that we have obtained from you or others participating in your care. The records reflect face-to-face encounters, telephone contacts, clinical impressions and interventions as they relate to your past, present or future. These records are kept electronically. You have the right to request a copy of the information contained in your file unless your therapist believes it reasonably likely to cause substantial emotional or physical harm to you or others, in which case you have a right to appeal.

_____Initial here if you have read and understood this section.

- **Limits of Confidentiality**

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

_____Initial if you have read and understood this section

- **Duty to Warn and Protect**

When a client discloses homicidal intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities.
In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

_____Initial if you have read and understood this section

- **Abuse of Children, Dependent Adults or Elders**

If the counselor suspects, or a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

_____Initial here if you have read and understood this section.

- **Insurance Providers** (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients.

- **Court Order**

If a court of law issues a legitimate subpoena for your records.
Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.
_____Initial here if you have read and understood this section.

Confidentiality for Children & Adolescents:

In order to ensure that a child or an adolescent client is receiving the best possible treatment, the parents and therapist must work together. In order to accomplish this, the youth needs to begin to trust the counselor, and have the confidence that anything discussed during a session will not be revealed to their parents. If a situation escalates into something potentially harmful or life threatening, the counselor will notify parents and other authorities as required by law.

_____Initial here if you have read and understood this section.

Cypress Counseling & Psychotherapy and its Therapists, *Do Not* make recommendations about placement of a child for custody disputes and do not provide investigation or reassessment to reach a determination about child abuse.

_____Initial here if you have read and understood this section.

Cypress Counseling & Psychotherapy/ and its Therapists, *do not* make or complete paperwork regarding short- or long-term disability documentation.

_____Initial here if you have read and understood this section.

Communication with Provider:

I understand that the communication with my therapist through text message is solely for logistics purposes including: Scheduling, cancelling and other information regarding sessions. We do not rely any information regarding therapy session's content or coping skills through the phone. If you experience an emergency, please call 911 or seek medical help.

_____Initial here if you have read and understood this section.

_____

Print Client's/Guardian full name

_____ _____

Client's/Guardian Signature Date

Limits of Confidentiality

Psychotherapy is confidential, with the below stated exceptions.

Duty to Warn: Therapists are mandated by law to disclose pertinent information discussed in therapy if the client has an intent or plan to harm another person. We are required to inform the intended victim and notify legal authorities.

Suicide/Self harm: Depression is common emotion expressed in therapy, but if a client is feeling hopeless enough to imply or disclose a plan for suicide; steps need to be taken to ensure safety.

This would include notifying the legal authorities as well as make reasonable attempts to notify the family.

Animal abuse: I will report animal abuse, including cases of neglect and hoarding.

Vulnerable Adults and Children: Mental health professionals are required by law to report stated or suspected abuse of a child or vulnerable adult to the appropriate social service agencies and/or legal authorities.

Prenatal Exposure to Controlled Substances: in keeping with protecting vulnerable populations, Mental Health Providers are required to report admitted use of controlled substances during pregnancy that are potentially harmful to the fetus.

Minors/Guardianship: Parents or legal guardians have the right to access a minor client's health information. Age of adult for psychotherapy is _____.

Insurance Providers: Information requested includes description of impairments, dates and times of service, diagnosis, treatment plans, treatment progress, prognosis for improvement, case notes and summaries.

I have read and understand the above-stated limitations to confidentiality. I accept the subsequent ramifications should there be a need to act on one of the above-stated exceptions. Other than the noted exceptions, if there are reasons to disclose my protected confidential information I understand that I will be provided a Release of Information form.

Client Signature: _____Date:_____

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Authorization for Payment/No Show Policy

I authorize Cypress Counseling & Psychotherapy and its therapists to charge my credit card for fees including:

- Fees for services rendered
- Missed appointments that are not cancelled within at least 24 hours advance notice
- No Show fee is $ 70.00

This authorization is ongoing and will be automatically revoked six months after the last date of service. Until that time, I authorize payments as described above. The therapist assigned to client will notify the cardholder of fees due prior to any charge made on the credit card number listed below and/or credit card listed under **IVYPAY** (payment system utilized by provider).

I understand this six month time period may be required to determine final amounts due and settle my account; and that my credit card may be billed during this time and expiration or cancellation of a credit card does not relieve me of unpaid debt.

Name on Credit Card:_____

Credit Card Number:_____

Expiration Date:_____

V Code (on back of card):_____

Billing Address:_____

_____

Email:_____

Signature:_____

Date:_____

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face
We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ___
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. __
- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. ___
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.___
- You will wear a mask in all areas of the office (I [and my staff] will too). ___
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff]. ___
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ___
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ___

- You will take steps between appointments to minimize your exposure to COVID. ___
- If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff] know. ___
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know. ___
- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth.___

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or my staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____
Patient/Client Date

_____ _____
Therapist Date

Cypress Counseling &
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12242 Queenston Blvd
Houston, Tx 77095
Suite C & F
281-837-6912

Teletherapy Informed Consent Form

I _____hereby consent to engage in teletherapy with a provider form Cypress Counseling & Psychotherapy. I understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy/coaching also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general Psychotherapy Services Agreement I received with this consent form.

3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

4. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if my provider believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not be improve, and in some cases may even get worse

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5. I accept that teletherapy does not provide emergency services. During our first session, my therapist and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

6. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

7. I understand that while email may be used to communicate with my provider, confidentiality of emails cannot be guaranteed.

8. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

I have read, understand and agree to the information provided above.

_____ _____

Client (or Guardian's) Signature Date

_____

Printed Name

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