Ashley M. Martinez, M.Ed., LPC Associate
Supervised by James F. Whittenberg, PhD, LPC-S
Office: (956) 230-8880 Fax: (956) 474-2753
Email:amartinez@figtree.care
www.figtreebehavioral.com

Basic Profile Information

First Name: _____ Middle Initial: _____
Last Name: _____ D.O.B _____
Current Physical Address: _____
Zip Code: _____
Preferred phone to reach you: _____
Email: _____

Patient Parent/Guardian Information
First Name: _____ Middle Initial: _____
Last Name: _____ Suffix: _____
Current Physical Address: _____ Zip Code: _____
Preferred phone to reach you: _____
Email: _____

Employer Information
Employer Name: _____Campus/Dept.: _____
Address: _____
City: _____State: _____ Zip Code: _____
Work phone: _____ Email: _____

COUNSELING SERVICES ARE CURRENTLY AVAILABLE ONLY THROUGH PRIVATE PAY AT THE RATE OF $65 PER SESSION.

Emergency Contacts

In the event of an emergency at Fig Tree Behavioral Wellness, who would you like us to contact first and second? Please list name, phone # and relationship.

Emergency Contact Name: _____
Phone # _____ **Relationship:** _____
Phone # _____ **Relationship:** _____

I hereby consent to the above the information to be true and correct to the best of my knowledge. I also consent to have my emergency contacts notified in the event of an emergency.

Print name: _____
Signature _____ Today's Date: _____

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Counseling Informed Consent

Below is important information about your counseling services. Please read them carefully. If you have any questions, please discuss them with your counselor.

Session Duration and Expectation:
A session is approximately 50 minutes. Clients who are late 15 minutes will need to reschedule and may be billed a cancellation fee. You are expected to attend scheduled appointments and to adopt an active role for treatment to be effective.

Fee Information:
All payments for services will be made the day of service unless prior arrangements have been made.

Initial Assessment - $65
Individual Counseling - $65
Telehealth Counseling - $65
Cancellation in less than 24hr - $50
No Show/No Call - $50

IMPORTANT NOTICE: *At this time, psychotherapy services are at the rate of $65 per session. Costs of therapy services are subject to change in the future. Your therapist will notify you of any changes in a timely manner before continuing therapy. Your therapist will also provide you with a new Good Faith Estimate so that your records may be updated.*

Cancellation Policy:
It is your responsibility to call or electronically cancel or reschedule all appointments that you cannot attend. After two no call/no show missed appointments, you may be sent an email requesting you contact Fig Tree Behavioral Wellness before terminating services with option to return in 6 months.

Confidentiality:
All information and records will be kept confidential and will be held in accordance with state laws regarding the confidentiality of such records and information. However, records and/or information will be released regardless of consent under the following circumstances:

1. According to state and local laws, counselors must report all cases of physical and/or sexual abuse or neglect of minors or the elderly to the appropriate agency;
2. It is a policy of Fig Tree Behavioral Wellness to report all cases in which there exists an immediate danger to self or others to the appropriate agency;
3. In the event that our records are subpoenaed by the court.

Emergency/On-Call Services:
Fig Tree Behavioral Wellness has limited on-call services. If in crisis, the client should call 911 or go to the nearest emergency room. For urgent calls please call the main phone number and speak with a representative.

Qualfications: A Licensed Professional Counselor Associate is a provisionally licensed professional counselor who has completed a master's level counseling program, passed the national state exam and is currently working toward full licensure by completing 3,000 of clinical counseling. LPC Associates are supervised outside the clinic by a LPC-Supervisor, licensed by the state of Texas. If you have any additional questions about this process, please feel free to ask your counselor.

ONLINE COUNSELING: Online counseling can provide you with the opportunity to access counseling support at a time and a place which is convenient for you. We will facilitate your success in finding a positive way to cope with personal issues and concerns.

Please be advised that email or any other online communication and phone/text conversations are not a secured form of communication. By signing below, you acknowledge that these types of communication will not be secured, and that you agree to the use of such communication.

Online Counseling limitations: Online counseling is geared towards a wide range of issues. Not all types of issues can be resolved through online counseling. If I consider face-to-face counseling or some other form of support to be more beneficial and appropriate to target your personal needs and presenting issues, I will advise you. At a time that online counseling will be deemed unsuitable, I will assist you with a referral to a suitable alternative source of support. Online communication may endure technical difficulties or disruptions in service. It is understood that when we communicate by internet or by any other electronic means, technical difficulties or disruptions in service will likely occur from time to time. Online counseling will not provide an emergency service for clients. If a disruption occurs at a time of crisis, the client agrees to immediately call 911 or go to the nearest emergency room. If the client considers the crisis not to require emergency services, the client agrees to immediately call the office at (956) 230-8880.

The way I work: I will provide, to the best of my ability, online counseling opportunities that endeavor to create a supportive, non-judgmental environment in which you will be given a time and a space to understand and gain insight of your situation. This process can foster growth and lead to a positive change in your life. There may be occasions where I ask questions about what you have written to me. This may be to seek a clearer view of your challenges or to clarify a misunderstanding in our communication. Open communication will facilitate your progress. Online counseling is different from face-to-face work, as misunderstandings may occur due to a lack of facial expressions, tone of voice, and non-verbal communication. I will facilitate your own process of our online encounters, to achieve your therapy goals.

Maintaining privacy of online exchanges with a counselor: Please ensure that you secure your computer and emails against unauthorized viewing by third parties. This may include adopting the use of password protection for all personal email accounts and documents etc. It is recommended that you do not engage in online counseling using a public computer, where the content of exchanges could be viewed by others in the close proximity. **For security reasons I would not advise that you send any therapeutic content in an "open email."** I would recommend that you send it as a Word document attachment to your email or using a password for further protection. By signing below, you agree that there will not be recording of audio or visual content of sessions without the signed release from all involved parties, and that any session content will not be posted or forwarded for others to see or hear without the signed release of all involved parties**.**

Online Consent: Your telehealth session will be conducted through psychology today. Appointments will take place on Texas local time and you must reside in the state of Texas. Your therapist will send you an email providing you a link to enter meeting. Once you've entered the meeting you will be placed in the waiting room until your therapist allows you in. Please keep this link secure. You are required to share your video so that you may be visible to your therapist. You are required to be in an area where you have privacy to comfortably express yourself during your therapy session. When either party experiences a technological breakdown, which prevents us from meeting online, I will give you the option of rescheduling and will credit you for the session if it has been paid. I will do my best to reschedule appointment at a convenient time for both parties. Cancellation/ No Show policies still apply to online sessions. By signing this form, you understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. You understand that you or your therapist can discontinue the telehealth session/visit if it is felt that the videoconferencing connections are not adequate for the situation. If you any questions or concerns regarding the platform, please discuss with your therapist. I am not able to provide online counseling to any person under the age of 18 without the consent of a parent or legal guardian. By signing below, you give permission and consent for the minor to use such services. If you have any questions, please feel free to ask. Your signature below indicates that you have read this document, we have discussed it, and you understand its contents.

Client Name _____

Phone number (in the event of technology breakdown) _____

Client Signature / Date _____

Parent/ Legal Guardian Signtaure / Date_____
(ONLY IF CLIENT IS A MINOR

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PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

1. You have the right to dignified and respectful care.
2. You have the right to know about and understand your physical/mental health condition.
3. You have the right to obtain any information requested by you to give informed consent before any treatment and/or procedure.
4. You have the right, at your own expense, to consult with another practitioner, psychiatrist or therapist.
5. You have the right to refuse treatment, as permitted by law, and to be informed of the consequences of your refusal.
6. You have the right to be treated in a safe environment that is free of physical and psychological threats.
7. You have the right to privacy regarding visitors, mail, and/or telephone conversations.
8. You have the right to expect that all communications and records regarding your care will be held confidential.
9. You have the right to expect continuity of care and that you will not be discharged or transferred to another facility without prior notice.
10. You have the right to request an itemized statement of all services provided to you through this practice.
11. You have the right to be informed of all practice rules and regulations governing your conduct as a patient and to understand the procedure for registering a complaint.
12. You have the right to treatment or accommodations required by your medical condition regardless of race, creed, sex, or national origin.

Patient Responsibilities

1. You are responsible for providing complete information about your health and for reporting the effects of your treatment.
2. You will be responsible for participating in the development of your plan of care.
3. No Show Policy for Psychiatric Services: 1st No show No Charge, 2nd No Show $100, 3rd No Show $100, and the patient will be discharged from services and will be responsible for any balance if balance cannot be collected through Ivy Pay.
4. Counseling Services No Show Policy differs. Please review Counseling Informed Consent.
5. You will be responsible for considering the rights of other patients and office personnel during your treatment in this practice.
6. You are responsible for following practice rules and policies.

Concern/Complaint Procedure

We want to hear from you if you have any concerns, complaints, or compliments regarding your treatment and care in our practice. Please inform any staff member. Response to a concern/complaint will take place within 24-48 business hours. Concerns/complaints will be monitored, and the information utilized to improve our clinic.

I have been made aware of my rights and responsibilities and the concern/complaint procedure.

Patient Signature:_____ Date: _____

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HIPAA—PATIENT PRIVACY NOTICE

- Your confidential healthcare information may be disclosed to other healthcare providers for the purpose of providing you with a continuum of quality healthcare.
- Your confidential healthcare information may be disclosed to your insurance provider for the purpose of receiving payment for providing you with healthcare services.
- Your confidential healthcare information may be disclosed to public official or law enforcement agencies in an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be disclosed to other healthcare professionals in the case of a healthcare emergency.
- Your confidential healthcare information may be disclosed to public health organizations or federal organizations in the matter of communicable diseases, defective devices, or a medication reaction.
- Your confidential healthcare information cannot be disclosed for purposes other than those, which are outlined in this notice.
- Your confidential healthcare information may only be disclosed after receiving written authorization from you. You have the right to revoke your permission to disclose confidential healthcare information at any time.
- You may be contacted by office personnel to remind you of appointments, healthcare treatment options or other health services that may be of interest to you.
- You have the right to restrict the use and disclosure of your confidential healthcare information to family members, friends, or others involved in your healthcare or payment for health care services. However, the practitioner may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of a medical emergency.
- You have the right to receive confidential communication about your healthcare status.
- You have the right to review and request a copy of any and/or all portions of your healthcare information. Fees may apply.
- You have the right to request changes be made to your healthcare information.
- You have the right to have a copy of this Privacy Notice upon request.
- This office is required by law to protect the privacy of its patients.
- This office will abide by the terms of this notice. We reserve the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.
- You have the right to complain to the Privacy Officer of this office and to the Secretary of Health and Human Services if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to:

Attn: Sean Hughes
Fig Tree Behavioral Wellness, LLC
2211 W. Lincoln St Ste #313
Harlingen, Tx 78552

All complaints will be investigated. No issue will be raised for filing a complaint with this clinic.

I acknowledge that I have reviewed the HIPPA-Patient Privacy Notice of Fig Tree Behavioral Wellness. I understand that a copy is also available to me upon request.

Client's Printed Name:_____
Client Signature:_____ Date:_____
Parent/ Legal Guardian Printed Name:_____
Signature:_____ Date: _____
(ONLY IF CLIENT IS A MINOR)

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Client's Authorization for the Release of Medical Records

You are hereby authorized to release medical record information, either in photocopies or through personal review such as indicated below:

Name of Client:
Date of Birth:

Permission request to Release or Receive information within organization:

Fig Tree Behavioral Wellness
513 E. Jackson Ave. Ste #312
Harlingen, TX 78550
956-230-8880

Purpose of Release: Optimal Plan of Care

Dates of specific treatment period to be released:

Information will be shared during the period patient is being treated by both Dr. Velma Hughes and Ashley Martinez, LPC Associate Supervised by Dr. James Whittenberg.

Specific authorization for the release of the following information listed below is given as indicated by client:

- Discharge Summary
- Consultation Report
- Counselor Progress Notes
- Laboratory Reports
- Any documentation of Medical Diagnosis
- Drug and Alcohol abuse treatment records
- Mental Health treatment records
- Other (specify):

I understand that this consent will automatically expire 180 days after termination of services. This consent is subject to revocation at any time, except that a disclosure made prior to the revocation or without knowledge of the revocation is not invalidated. You and the counselor, the counselor's office, and counselor's staff are hereby released from legal responsibility or liability for the release of the records to the extent indicated and authorized herein.

Client's Printed Name:_____
Client Signature:_____ Date:_____
Parent/ Legal Guardian Printed Name(ONLY IF CLIENT IS A MINOR)_____
Signature:_____ Date:_____

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Client Intake Assessment

Name:_____ **Date:**_____
DOB: _____
Email:_____

Who referred you to our office, or how did you learn about our office?

_____

Reason for Referral/Main Complaint (i.e., depression, anxiety, job stress, relationship, addiction)

_____

Emergency Contact Information
In case of an emergency, whom should we contact?
Name: _____
Relationship: _____
Phone Number: _____

☐ Permission for telephone message to be left.

History Information -Who is providing the history information?
☐ The client ☐ The client's guardian ☐ Other: _____

Please describe the current complaint or problem as specifically as you can, in your own words.

_____

_____

How long have you experienced this problem, or when did you first notice it?

_____

What stressors may have contributed to the current complaint or problem?

_____

What have you done to attempt to resolve the current complaint or problem?

_____

Check all words/phrases that describe what you are experiencing and explain if possible.

☐ Drug/Alcohol abuse/dependence ☐ Addiction (porn, shopping, Internet, gambling, sex, etc.)
☐ Depression/Sad/Down feelings ☐ High/Low energy level ☐ Angry/Irritable
☐ Loss of interest in activities ☐ Difficulty enjoying things ☐ Crying spells
☐ Decreased motivation ☐ Isolation ☐ Mood Swing
☐ Change in weight or appetite ☐ Change in sleeping pattern ☐ Paranoia
☐ Thoughts of hurting or killing yourself ☐ Self-harm/Cutting/Burning yourself
☐ Thoughts of hurting/killing others ☐ Poor concentration/Difficulty focusing
☐ Feelings of hopelessness/Worthlessness ☐ Feelings of shame or guilt
☐ Feelings of inadequacy/Low self-esteem ☐ Anxious/Nervous/Tense feelings
☐ Panic attacks ☐ Racing or scrambled thoughts
☐ Bad or unwanted thoughts ☐ Flashbacks/Nightmares
☐ Phobic or fearful ☐ Hearing voices/Seeing things not there
☐ Impulse Control/Oppositional/Conduct ☐ Rituals of counting, washing, checking
☐ Trauma/assault/rape ☐ Sexual Abuse ☐ Sexual Identity
☐ Domestic Violence ☐ Separation/Divorce ☐ Blended family
☐ Parenting concerns ☐ Feelings of being cheated ☐ Infidelity
☐ Parenting concerns ☐ Relationship Issues ☐ Perfectionism
☐ Distorted body image ☐ Loss of control over eating ☐ Rules about eating
☐ Binge eating/Purging ☐ Eating inedible objects ☐ Job loss
☐ Indecisiveness about career ☐ Job problems/stress ☐ Unemployed
☐ Other: _____

Previous Treatment

Have you received or participated in previous counseling and/or therapy? ☐ Yes ☐ No
If Yes, please list (names and dates): _____

Have you had hospital stays for psychological concerns? ☐ Yes ☐ No
If Yes, please list (facilities and dates): _____

Developmental History

Are you aware of any difficulties or complications during the time your mother was pregnant with you? ☐ Yes ☐ No

If Yes, explain: _____

Did you walk, talk, and read on time? ☐ Yes ☐ No

If No, explain: _____

Medical History

List any current or important past medications (name, dosage, schedule):

_____

_____

Please list any allergies: _____

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your lifetime: _____

Do you have a primary care physician (PCP)? ☐ Yes/ Name:_____ ☐ No

Family history of alcohol/drug abuse (Please specify):

_____

Family history of mental illness (Please specify):

_____

History of suicidal or homicidal plan or attempt: _____

History of physical, emotional, or sexual abuse: _____

Additional Information

Summarize your goals for counseling/therapy:

_____

What do you do to cope with stress?

_____

Who can you rely on for help and support?

_____

What are your strengths?

_____

What are your limitations?

_____

What are your main hobbies and interests?

_____

Who can you contact if you don't feel safe or want to harm someone (name/phone number)?

_____

How do you think I could best help you? What do you need from your counselor? If you've been in therapy before, what can your counselor do differently for you this time?

_____

_____

_____

_____ _____

Signature of client or guardian **Date**

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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