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therapy & healing

Please take time to read the following information in full. This packet includes 12 pages of information (including this cover page).

Please complete the following packet and scan and e-mail back to hold your appointment. Submitting back via e-mail is considered your consent for e-mail communication. You may also print this form and bring with you to your appointment. ALL SIGNATURES MUST BE MADE IN INK. ELECTRONIC SIGNATURES WILL NOT BE ACCEPTED. A credit card is required to hold your appointment time.

Our office is located in a red brick building on Yoakum Blvd. Ask your therapist for the code to enter the front door of the building.

4314 Yoakum Blvd. Suite 21
Houston, TX 77006
www.revivetherapy.com

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Name:_____ Date:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone:_____ Date of Birth:_____

Email Address: _____

Marital Status: __ Single __ In a relationship __ Living with partner
__ Married __ Divorced

Partner's Name: _____

Partner's Phone: _____ Partner's Date of Birth: _____

Partner's Email Address: _____

Emergency Contact

Name: _____ Phone: _____

Who may we thank for your referral: _____

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PRIVACY NOTICE

REVIVE therapy & healing has implemented the following policy regarding patient privacy and confidentiality. The office holds patient record information confidential and will only use your information for treatment, payment and billing, and with insurance companies if you request a statement for insurance reimbursement. Our staff may also have access to your records for administrative purposes.

DISCLOSING RECORD INFORMATION

Release of information to any other entity will require a signed authorization from you. This request must be dated, show to whom the information is to be released or requested, and the specific information to be released or acquired. These authorizations will have an end date if you ask for it. Additional requests beyond the end date will require a new authorization. I will keep a record of all disclosures in your file. This information will be available for you to review. We will not participate in any court proceedings at any time, even with your release.

YOU HAVE A RIGHT TO ACCESS YOUR RECORDS

You can review and obtain copies of your records. There are some limitations in accordance with the Texas Health and Safety Code § 611.004. Upon receipt of a written request, I will make the records available within 10 days. Records will be sent via regular mail unless you request in writing to have them sent via electronic mail. Should something unexpected occur to me, such as serious injury or death, your records will be released to my colleague, Beth Christopherson, MS, LCSW. 832.554.6688.

ACKNOWLEDGMENT

I acknowledge that I have reviewed this privacy notice.

_____

Signature

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INFORMED CONSENT

QUALIFICATIONS AND CREDENTIALS

Emily deAyala, PhD, LPC, LMFT is president and lead psychotherapist at REVIVE therapy & healing. Emily completed her undergraduate work at the University of Texas at Austin, where she graduated with honors, receiving her BA in Psychology and her minor in Educational Psychology. She then received her Master of Arts in Counseling and eventually earned her PhD in Clinical Sexology. Emily is a member of the American Association of Marriage and Family Therapists (AAMFT), the American Association of Sexuality Educators, Counselors, and Therapists (AASECT), and Houston Group Psychotherapy Association (HGPS). She is licensed by the Texas State Board of Examiners in Professional Counselors: Phone: 512.834.6658. Her LPC license number is 66399. She is also licensed by the Texas State Board of Examiners of Marriage and Family Therapists. Her LMFT license number is 202584. Phone: 512.834.6657. Mail Code 1982, P.O. Box 149347, Austin, TX 78714.

CLIENT RIGHTS

- You have a right to be treated respectfully and with dignity.
- You have a right to decide how long you stay in treatment.
- You have a right to information about your treatment, including records of your treatment. Note: your records will be destroyed in accordance with state board rules.
- You have a right to discontinue or refuse treatment at any time.
- You have the right to express dissatisfaction with treatment directly to me and/or to the boards listed above.
- You have a right to confidentiality, with certain legal and ethical **exceptions**:
    - If you threaten grave bodily harm or death to yourself or another person, your counselor may inform the appropriate authorities.
    - If a court of law issues a court order, the law requires the information specifically described in the order be provided.
    - If you reveal information suggesting child, elder or disabled person abuse and neglect, state law requires the reporting of this to the appropriate authorities.
    - If you are being seen by order of a court of law, the results of treatment or tests ordered may be revealed to the court.
    - If you authorize me and/or my agents to file a claim and bill a third party payer, then you are authorizing me and/or my agents to release any medical or necessary information to process these claims.
    - You have a right to know I may consult with other clinicians to review my work with you.
    - If you are under the care of another licensed professional counselor, I am obligated to request to inform that provider.
    - If I suspect sexual exploitation by another mental health provider, I am obligated to notify appropriate licensing boards.

Signature: _____

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COUNSELING PHILOSOPHY

My therapeutic approach can best be described as integrative, meaning I pull from many different approaches. This allows me to tailor treatment to meet your unique needs. I am also a systemic therapist, meaning that I will examine the patterns of your relationships with others and within yourself. I typically conduct a complete biopsychosocial and sexual history as part of my assessment, which may take between 1-4 sessions. I often utilize a treatment intervention called Eye Movement Desensitization and Reprocessing (EMDR). I also offer hypnotherapy. I will explain this intervention in full and provide a separate EMDR or Hypnosis Informed Consent if I believe you would be a good candidate.

FINANCIAL ARRANGEMENT

Service	Rate
First Session (45-50 min)*	$225.00
Subsequent Sessions (45-50 min)	$200.00
Package of 4 Sessions (45-50 min each)**	$750
Telephone Consultation (with client or other provider)	Billed per minute at $4/min
Missed Sessions (Not cancelled within 24 hours)	**The full price of the session**

Payment is due in full at the time of your session. I accept the following forms of payment: Cash, Check, MasterCard, Visa, Amex, and Discover. **Cash, check, or debit is strongly preferred.**

It is the policy of the office that you call 24 hours prior to your scheduled appointment time to notify the office that you will not keep your appointment. In the event that you do not call to cancel your session 24 hours in advance, you will be held responsible for payment for that session and/or your credit card on file will be automatically charged. If continuous cancellations (even those with 24 hour notice) become a pattern, your therapist reserves the right to refer you to another treatment provider.

*All session times include time to collect payment and schedule your next appointment.
** Package sessions are non-refundable. No exceptions.

Should you desire to file for out of network benefits with your insurance company, I will provide you with a superbill every four visits that you can submit to your insurance company. I will provide you with my National Provider Identification (NPI) number only. If there is an issue with reimbursement, I will do my best to assist you, but you will be billed for any correspondence with your insurance company. Also, please note that reimbursement is between you and your insurance company, and full payment for your session is still required at the time of the service.

Signature_____

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EMERGENCY POLICY

I check my voice mail and messages several times a day and can be reached by calling the main office number at 832.301.9160. I will make every attempt to return your call within 24 hours or by the next business day. If you do not hear from me within this time frame, please try again.

If I am out of the office for an extended period, I will leave a message on my voice mail to that effect. Messages left may not be returned until I return to the office.

In case of an emergency, you may call any one of the following emergency numbers: 911, United Way Crisis Hotline (713) HOTLINE, MHMRA Crisis Unit (713) 970-7070 or go to the nearest hospital emergency room or fire department for assistance.

OFFICE POLICIES

Please arrive no earlier than 15 minutes before your appointment. We strive to begin and end all appointments on time. While we encourage a frank and open discussion, you should understand the boundaries and limitations of a therapeutic relationship. We offer counseling and psychotherapy services only. We reserve the right to refer you to another treatment provider if we deem there is a loss of respect for the boundaries therapeutic relationship on your end. We make it our policy not to become involved in any court proceedings or disputes (such as divorce or legal or HR proceedings) outside the office, except that which is mandated by the licensing board. Please note you will be charged your hourly rate for any non-therapeutic work on your behalf. Finally, please reserve e-mail communication for scheduling only.

_____ _____

Signature Date

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INFORMED CONSENT DOCUMENT FOR INDIVIDUALS IN COUPLES COUNSELING

To protect your privacy, I have put the following policies in effect regarding couples counseling.

Issues concerning personal privacy and professional confidentiality are somewhat more complicated when working with couples. In addition to the exceptions to confidentiality outlined in your New Client Packet, work with couples sometimes requires certain additional compromises in privacy.

For example, part of our couples work may require that we meet individually with you and at other times individually with your spouse or partner. While we typically desire full disclosure in a relationship, there may be times when your partner and therapist have agreed to keep certain information private from you.

You need to be aware of some of the complications that can arise from this policy. For example, we might learn that (a) your partner had an affair and it is now ended; (b) is still having an affair and wants help ending it; or (c) is still having an affair and has no intention of ending it.

It is our policy to discontinue couples treatment if one partner is actively in an affair and is withholding this information. We understand that this may result in the information not being shared, but we hold the belief that productive couples therapy will not occur while an active affair is being kept secret.

In brief, out policy concerning private communication is that we reserve the right to withhold from you or your partner information that we learn from you or your partner during individual therapy sessions. Our commitment to each of you is to assist you in the kind of relationship you desire. In addition, we strive for couples to develop transparent, honest, and trusting relationships.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signature _____

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RELEASE OF INFORMATION – Fill out only AS NEEDED or DESIRED

Please read each item carefully. Mark "yes" or "no," sign and date. Feel free to leave blank anything you are unsure of. Authorization allows for **two-way unfettered communication**. If you have any questions, please ask for clarification.

I authorize Emily deAyala, PhD, LPC, LMFT to contact my primary care physician (PCP) to coordinate care.

Yes___ No___ Doctor's Name:_____ Phone: _____

I authorize Emily deAyala, PhD, LPC, LMFT to contact my psychiatrist to coordinate care.

Yes___ No___ Doctor's Name:_____ Phone: _____

I authorize Emily deAyala, PhD, LPC, LMFT to contact my other psychotherapist to coordinate care.

Yes___ No___ Doctor's Name:_____ Phone: _____

I authorize Emily deAyala, PhD, LPC, LMFT to contact _____
to coordinate care.

Yes___ No___ Phone: _____

_____
Print Name

_____ _____
Signature Date

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CREDIT CARD AUTHORIZATION FORM
(REQUIRED AT TIME OF APPOINTMENT)

READ CAREFULLY – IT IS YOUR CHOICE WHETHER TO COMPLETE THIS PAGE AND RETURN VIA E-MAIL OR COMPLETE AT THE OFFICE. REVIVE WILL NOT BE HELD LIABLE FOR ANY INFORMATION SUBMITTED ELECTRONICALLY. MUST BE COMPLETED EVEN IF PROVIDED ON THE PHONE.

Person Financially Responsible

Name:_____

Credit Card Information: This information will be used to charge a nonrefundable $25 fee to hold your first appointment. This $25 is deducted from the cost of your first visit. Otherwise, this information is kept on file and used only when there is a late cancellation and/or no show. If you wish to pay regularly with your credit card, your card must be present to swipe at the session. This information will also be used to communicate with your credit card company if necessary or if you fail to make a payment.

Card Type: __ MasterCard __ Visa __Amex __Discover

Name as it appears on the card:_____

Card #:_____ Expiration:_____

Security Code:_____

FULL Billing Address: _____

_____ _____
Signature of Client Date

_____ _____
Signature of Person Financially Responsible Date

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MEDICAL AND PSYCHIATRIC HISTORY

Please list your current medications.

MEDICATION	PURPOSE	STRENGTH	TAKEN HOW OFTEN

Please list and describe any major medical events or diagnoses.

_____

_____

My current physical health can best be described as: Good___ Fair___ Poor___

I have experienced the following symptoms in the past two months. Check all that apply.

	Change in sleep		Change in sex drive
	Change in weight		Change in appetite
	Headaches		Memory problems
	Concentration difficulty		Dizziness or fainting
	Difficulty breathing		Lack of Energy
	Digestive problems		Urination difficulty
	Menstrual pain		Nausea
	Numbness or tingling		Poor balance or trouble walking

	High blood pressure		Heart disease
	Diabetes		Tuberculosis
	Thyroid problems		Drug addiction
	Alcoholism		Stroke
	Cancer		Asthma
	(other)		(other)

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I have experienced the following symptoms in the past two months. Check all that apply.

	Sadness		Loneliness		Nightmares
	Flashbacks		Dissociative states		Crying spells
	Anxiety/Panic attacks		Temper outbursts		Self harm/abuse
	Harm to others		Guilt		Fear
	Excessive worry		Mind racing		Mood swings
	Irritability		Delusions		Hallucinations
	Anger		Aggression		Obsessive thoughts
	Compulsive behavior		Paranoia		Somatic concerns
	Sexual dysfunction		Loss of relationship		Withdrawal

In the past 12 months, have you seen another psychotherapist or mental health provider?
Yes___ No___

In your lifetime, have you ever seen a psychotherapist or mental health provider?
Yes___ No___

In your lifetime, have you ever been in a state hospital or psychiatric facility?
Yes___ No___

Has anyone in your family ever been in a state hospital or psychiatric facility?
Yes___ No___

In your lifetime, have you ever thought about or attempted suicide?
Yes___ No___

If yes, please explain: _____
_____
_____

Are you currently experiencing any suicidal thoughts or feeling suicidal? Yes___ No___

If yes, please explain: _____
_____
_____

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