

Please take time to read the following information in full. This packet includes 13 pages of information (including this cover page).

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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.

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: \_\_\_\_\_

## 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.

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Signature

INFORMED CONSENT

QUALIFICATIONS AND CREDENTIALS

Emily Jamea, 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. 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: \_\_\_\_\_

**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**

<u>Service</u>	<u>Rate</u>
First Session (45 min)	\$250.00
Subsequent Sessions (45 min)	\$215.00
Package of 4 Sessions (45 min)**	\$825
<b>Sessions missed or cancelled with less than 24 hrs notice</b>	<b>The full price of the session</b>

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 \_\_\_\_\_

**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.

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Signature

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Date

**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, our 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 \_\_\_\_\_

## INFORMED CONSENT FOR TELEHEALTH SERVICES

Telehealth counseling is the term used to describe mental health services provided via technological means. Telehealth can be done via text, phone, or video. The only telehealth counseling I provide is through video.

### **Benefits, Risks, and Drawbacks of Telehealth Counseling**

Benefits include:

- Flexibility in session location
- No travel time to/from session
- Flexibility in appointment time
- Ability to access a therapist from afar

Risks and Drawbacks include:

- Services may feel less personal
- Technology is never perfect. There will be breakdowns or interruptions in service due to something malfunctioning. For some, this may cause distress which means that telehealth counseling may be more harmful than beneficial.
- Most insurance carriers do not yet cover telehealth therapy services.
- If you are in a mental health crisis, the therapist will need to use the assistance of your "emergency contact" and/or send for professional crisis support

### **Technology Resources**

I have BAA agreements and HIPAA compliance with the following entities:

- G-mail
- Constant Contact
- Psychology Today Video Telehealth
- Chase Merchant Services (You are also welcome to pay with Zelle or Venmo)

You will need to ensure that you have the technological capabilities to use video and audio. You can either use a built-in camera and microphone or an external camera and microphone. You will also need reliable internet connection that can support the video conferencing application.

Should we have poor connection or get disconnected via video, you will need to have access to a phone line for us to continue the session. If we get disconnected through video, I will immediately call you on the back-up number you provide at the beginning of each session.

**Confidentiality**

Just as we would for in-person for therapy, it is important to have a confidential session when working via telehealth means. Therefore, to participate in video counseling, you will need to find a location that will be private and free from distractions. If you cannot do this, then video counseling is not appropriate.

**Safety Precautions**

To participate in video counseling, you will need to be willing to identify an emergency contact for each session. This emergency contact must be willing to be contacted should I determine that you are in a mental health crisis. You must also share your physical address for each session so that I will know where to send emergency services should I deem necessary.

At all times, should you have a medical or mental health emergency that puts your physical safety at risk, please call 911. If I receive a phone message, email or text that causes me genuine concern that your safety is at risk and I then cannot get a hold of you, I will notify the police to do a welfare check.

**Additional Policies**

- You must be fully and appropriately clothed while participating in session, even if the camera does not capture your whole body.
- No sessions will be conducted while you are driving.
- Find a place where the background noise will not interfere with the session.
- No eating while we are in session.
- Pick a place with good lighting. Please set the camera at or slightly above eye level and aim the camera so that your shoulders and head are in the frame.

**Termination of Telehealth Counseling**

If I determine at any point that video counseling is ineffective or detrimental to your growth or health, then I reserve the right to prepare for proper termination of the use of video.

**Agreement**

I have read and agree with the stated treatment policies described above.

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

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 Jamea, PhD, LPC, LMFT to contact my primary care physician (PCP) to coordinate care.

Yes\_\_\_ No\_\_\_ Doctor’s Name:\_\_\_\_\_ Phone: \_\_\_\_\_

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

Yes\_\_\_ No\_\_\_ Doctor’s Name:\_\_\_\_\_ Phone: \_\_\_\_\_

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

Yes\_\_\_ No\_\_\_ Doctor’s Name:\_\_\_\_\_ Phone: \_\_\_\_\_

I authorize Emily Jamea, PhD, LPC, LMFT to contact \_\_\_\_\_  
to coordinate care.

Yes\_\_\_ No\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

CREDIT CARD AUTHORIZATION FORM  
(REQUIRED AT TIME OF APPOINTMENT)

YOU MAY COMPLETE THIS AND SEND VIA E-MAIL OR PROVIDE YOUR CC INFORMATION OVER THE PHONE (INSTRUCTIONS BELOW).

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. 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: \_\_\_\_\_

**\*\*\*If you wish to provide card information over the phone, please write "provided over the phone" on the Card# line. You must still sign and date.\*\*\***

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Financially Responsible

\_\_\_\_\_  
Date

## 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.

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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.

<input type="checkbox"/>	Change in sleep	<input type="checkbox"/>	Change in sex drive
<input type="checkbox"/>	Change in weight	<input type="checkbox"/>	Change in appetite
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Memory problems
<input type="checkbox"/>	Concentration difficulty	<input type="checkbox"/>	Dizziness or fainting
<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	Lack of Energy
<input type="checkbox"/>	Digestive problems	<input type="checkbox"/>	Urination difficulty
<input type="checkbox"/>	Menstrual pain	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	Numbness or tingling	<input type="checkbox"/>	Poor balance or trouble walking

<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	Drug addiction
<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	(other)	<input type="checkbox"/>	(other)

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

<input type="checkbox"/>	Sadness	<input type="checkbox"/>	Loneliness	<input type="checkbox"/>	Nightmares
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	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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_