1005 North Flood, Suite 137
Norman, OK 73069

Gail P. Wilcox, LADC, LPC.
Gwilcox@EnvisionCounselingOK.com

P. O. Box 1762
Norman, OK 73070

CLIENT INFORMATION

Client Name: ________________________________

Date Of Birth: ________________________________

SSAN: ________________________________

Full Address:________________________________

____

E-Mail Address: ____________________________

Home Phone________________________________

Cell Phone: ________________________________

Work Phone________________________________

Parent/Guardian Name (if client is minor):

____

Phone (if different than above): _______________

Today's Date: _______________

Employer/ School ______________________________

Occupation/major: ______________________________

Work/school hours: _____________________________

Highest Grade: _________ current student? _______

Marital Status: _________________________

Emergency Contact:

Name: _______________________________________

Relationship to Client: __________________________

Phone_________________________________

Do you have a Medical Referral: **yes no**

From: ________________________________

Phone: ____

CURRENT SITUATION

Why are you seeking counseling now?

____

Have you experienced any MAJOR life changes in the past year: **yes no**.

If yes: death of family/friend ___ move ___ job/school change ___ relationship stress/end ___

Major illness: self or someone close to me: ________________________________

If other, list the change(s): ____

How would you describe your health: Poor Unsatisfactory Satisfactory Good Excellent

Sleep problems? No Yes: Sleeping too much Sleeping too little Poor sleep quality how long? __________

How often do you exercise? ______ What type of exercise? __________________________

Do you drink alcohol? No Yes If yes, how much & how often? ____________________________________

Are you concerned about your drug use? Yes No. Alcohol use? Yes No.

Any difficulty with appetite or eating habits? No Yes Eating less Eating more Binging Restricting

Any significant weight change in the last 2 months? No Yes: Gaining Losing Amount: ___________

Are you current prescribed any medication? yes no; If yes, please list medications & dosage or provide a list

____

Any Medical or mental health concerns/diagnosis: ____

____

Have you had any suicidal thoughts in the last month? **Yes No** In the past? **Yes No**

If there is anything else that you would like to share? ____________________________________

____

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Please list those you have a significant with such as: Child, Spouse/partner, Sibling, parent.

Name: ______________________________Age: _________ Relationship: _________ Live with you? Y or N
Name: ______________________________Age: _________ Relationship: _________ Live with you? Y or N
Name: ______________________________Age: _________ Relationship: _________ Live with you? Y or N
Name: ______________________________Age: _________ Relationship: _________ Live with you? Y or N

Are you receiving counseling or seeing a psychiatrist? yes no
Mental Health Provider:_______________________________________Date of last appointment: ______________
Address: ____Phone: ______________________________

Name of Physician____ Date of Last Physical: ________________
Address: ____Phone: ______________________________

The above is true to the best of my knowledge. ____
CLIENT SIGNATURE **Date**

Third party billing AUTHORIZATION: I authorize **Gail P. Wilcox, LADC, LPC** to bill me, my insurance and/or other individual listed below**:**

1) FOR EACH SERVICE WITHIN 30 DAYS OF SERVICE: 1 hour session: $_________ Assessment: $__________
2) **FOR A MISSED SESSION** at the regular session rate if I cancel less than 24 hours in advance of my appointment. I understand this is not covered by insurance.
3) **A MONTHLY LATE FEE OF 10% IF AND WHEN MY PAYMENT BALANCE BECOMES 30 DAYS PAST DUE**

Primary Insurance company:______________________________ **Member #:** ________________________

Primary insured: __________________________________ **Date of birth:** __________ **Group #** ______________
Primary insured SSAN: __________________________________ **Copay**: ________________ **Deductible**: _____________

Secondary Insurance company:______________________________ **Member #:** ________________________

Primary insured: __________________________________ **Date of birth:** __________ **Group #** ______________
Primary insured SSAN: ______________________________________ **Copay**: ________________ **Deductible**: _____________

Billing Address: ____ ____
E-mail address for invoices and receipts
City, State: ____ Zip Code: ________________

I agree to pay charges as indicated above. ____ ________________
CLIENT OR RESPONSIBLE PARTY SIGNATURE Date

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Please initial at the beginning of each section to confirm you read the section and agree to the terms.

COUNSELOR-CLIENT SERVICE AGREEMENT

This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

______THERAPY SERVICES (including psychotherapy, counseling and career or life coaching)
Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client, you have certain rights and responsibilities that are important for you to understand. You should also be aware of the legal limitations to those rights. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of therapy often requires discussing the unpleasant aspects of your life. However, therapy typically has great benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems.

Career counseling and career coaching are similar in nature to traditional therapy. However, the focus is generally on issues such as career exploration, career change, personal career development and other career related issues. Career counseling is the process of helping the candidates to select a course of study that may help them to get into a rewarding job or make them employable. A career counselor helps candidates to get into a career that is suited to their aptitude, personality, interest and skills. Sometimes an individual may feel stuck and unable to get hired.

There are no guarantees about the outcomes or the duration of treatment. Therapy requires a very active effort on your part. In order to be most successful, you will have to work outside of sessions on things we discuss.

The first session or initial consult and is intend for us to decide if we want to work together. It is an opportunity for us to meet and discuss your initial concerns, needs, and goals. You will complete the necessary initial paperwork. I will answer your questions about treatment and my qualifications. The next 1-2 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me.

If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion at your expense.

______APPOINTMENTS
Appointments will ordinarily be 50-60 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 48 hours notice. If you miss a session without canceling, or cancel with less than 48 hour notice, my policy is to collect the amount of your payment [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

______MY STANDARD PROFESSIONAL FEES:

The initial consultation/hour:	$120.00
Assessment and intake:	$250.00
An Individual session/hour:	$120.00
Telephone Consult/per 15 minutes):	$ 30.00

These are not paid by insurance:

Returned payments:	$ 35.00
Court/Probation/Employment Reports:	$ 20.00/15 minutes
Court Appearance/hour (includes travel and wait time):	$300.00*
Résumé review:	free
Résumé development/hour (typically 2 hours)	$ 75.00
Career assessments & reports (out of session)	$ 75.00

Note: You are responsible for paying at the time of your session unless prior arrangements have been made. Payments can be made by cash, credit or by using PAYPAL. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

*$600 will be required in advance of the court date with the balance due within 30 days of my court appearance regardless of the outcome of the court proceedings and is required even if another party compels me to testify.

_____INSURANCE
Insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs sometimes require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. While a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. If you have a health insurance policy, it will likely provide some coverage for mental health treatment.

You should also be aware that most insurance companies require a clinical diagnosis in order to provide reimbursement. Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). I will be glad to review the information used to determine a diagnosis.

If I am in network with your insurance company, I will confirm your coverage and file according to the insurance company's requirements. Check with me regarding possible insurance acceptance and any information I will need in order to file for payment with your insurance company. Some services provided are not covered by insurance and will be your responsibility. Please note if you have a deductible, you will be responsible for the full payment (at the negotiated rate for your insurance policy) until your deductible is met.

If I am not in network with your insurance, I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage, for the payment in full, and for filing for reimbursement. I can not guarantee the amount you will be reimbursed by your insurance company. Check with me regarding possible insurance acceptance and any information you need in order to file for reimbursement with your insurance company. I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers and many have separate deductibles for in network and out of network providers which must be met before they will reimburse you. If you prefer to use a participating provider, I will attempt to refer you to a colleague.

_____PROFESSIONAL RECORDS
I am required to keep appropriate records of the psychological testing, assessments, and services that I provide. Your records are maintained in a secure manner IAW HIPPA and 42 CFR part 2 and other appropriate rules and regulations. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

_____CONFIDENTIALITY
My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Client Rights. You have been provided with a copy of that document. Please remember that you may reopen the conversation at any time during our work together. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality.

_____CONFIDENTIALITY BETWEEN PARENTS & MINORS
While privacy in therapy is crucial to successful progress, parental and other family involvement can also be essential. For adults in treatment, family members may request input into the individual's care; however, it is the client's choice regarding what information, if any, is shared with other individuals including family members. For children under 17, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless there is a safety concern (see also the Notice of Client Rights for exceptions), in which case I will make every effort to notify

the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised. Effective therapy is facilitated when all clients have confidence that their communications are kept confidential. Payment of fees does not entitle the payer to protected information regarding any other individual.

____CONTACTING ME
I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact the reachout hotline 1-800-522-9054, 2) go to your Local Hospital Emergency Room, or 3) call 911. I will make every attempt to inform you in advance of planned absences, and if possible provide you with the name and phone number of another mental health professional.

____OTHER RIGHTS
If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, or national origin. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

CONSENT TO PSYCHOTHERAPY
My signature below indicates that I have read this Agreement and the Notice of Privacy Practices and agree to the above terms. Additionally, I give permission to the counselor/therapist listed below to complete an assessment and treatment if recommended.

______________________________ ______________________________
Signature of Client Printed Name of Client

______________________________ ______________________________
Signature of Parent or Guardian Printed Name of Parent or Guardian

______________________________ ______________
Relationship Date signed

______________________________ Gail P. Wilcox, LADC, LPC. ______________
Signature of Counselor Printed Name of counselor. Date signed

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What I Want From Treatment

DO YOU WANT THIS FROM TREATMENT?		NO 0	Maybe 1	Yes 2	YES! 3
1.	I want to receive detoxification, to ease my withdrawal from alcohol or other drugs.	0	1	2	3
2.	I want to find out for sure whether I have a problem with alcohol or other drugs.	0	1	2	3
3.	I want help to stop drinking alcohol completely.	0	1	2	3
4.	I want help to decrease my drinking.	0	1	2	3
5.	I want help to stop using drugs (other than alcohol).	0	1	2	3
6.	I want to stop using tobacco.	0	1	2	3
7.	I want to decrease my use of tobacco.	0	1	2	3
8.	I want help with an eating problem.	0	1	2	3
9.	I want help with a gambling problem.	0	1	2	3
10.	I want to take Antabuse (a medication to help me stop drinking).	0	1	2	3
11.	I want to take Trexan (a medication to help me stop using alcohol or heroin).	0	1	2	3
12.	I want to take methadone.	0	1	2	3
13.	I want to learn more about alcohol/drug problems.	0	1	2	3
14.	I want to learn some skills to keep from returning to alcohol or other drugs.	0	1	2	3
15.	I would like to learn more about 12-Step programs like Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).	0	1	2	3
16.	I would like to talk about some personal problems.	0	1	2	3
1.	I need to fulfill a requirement of the courts.	0	1	2	3
17.	I would like help with problems in my marriage or close relationship.	0	1	2	3
18.	I want help with some health problems.	0	1	2	3
19.	I want help to decrease my stress and tension.	0	1	2	3
20.	I would like to improve my health by learning more about nutrition and exercise.	0	1	2	3
21.	I want help with depression or moodiness.	0	1	2	3
23.	I want to work on my spiritual growth.	0	1	2	3
24.	I want to learn how to solve problems in my life.	0	1	2	3
25.	I want help with angry feelings and how I express them.	0	1	2	3
26.	I want to have healthier relationships.	0	1	2	3
27.	I would like to discuss sexual problems.	0	1	2	3
28.	I want to learn how to express my feelings in a more healthy way.	0	1	2	3
29.	I want to learn how to relax better.	0	1	2	3
30.	I want help in overcoming boredom.	0	1	2	3
31.	I want help with feelings of loneliness.	0	1	2	3
32.	I want to discuss having been physically abused.	0	1	2	3
33.	I want help to prevent violence at home.	0	1	2	3
34.	I want to discuss having been sexually abused.	0	1	2	3
35.	I want to work on having better self-esteem.	0	1	2	3

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What I Want From Treatment

36.	I want help with sleep problems.	0	1	2	3
37.	I want help with legal problems.	0	1	2	3
38.	I want advice about financial problems.	0	1	2	3
39.	I would like help in finding a place to live.	0	1	2	3
40.	I could use help in finding a job.	0	1	2	3
41.	Someone close to me has died or left, and I would like to talk about it.	0	1	2	3
42.	I have thoughts about suicide, and I would like to discuss this.	0	1	2	3
43.	I want help with personal fears and anxieties.	0	1	2	3
44.	I want help to be a better parent.	0	1	2	3
45.	I feel very confused and would like help with this.	0	1	2	3
46.	I would like information about or testing for HIV/AIDS.	0	1	2	3
47.	I want someone to listen to me.	0	1	2	3
48.	I want to learn to have fun without drugs or alcohol.	0	1	2	3
49.	I want someone to tell me what to do.	0	1	2	3
50.	I want help in setting goals and priorities in my life.	0	1	2	3
51.	I would like to learn how to manage my time better.	0	1	2	3
52.	I want help to receive SSI/disability payments.	0	1	2	3
53.	I want to find enjoyable ways to spend my free time.	0	1	2	3
54.	I want help in getting my child(ren) back.	0	1	2	3
55.	I would like to talk about my past.	0	1	2	3
56.	I need help in getting motivated to change.	0	1	2	3
57.	I would like to see a female counselor.	0	1	2	3
58.	I would like to see a male counselor.	0	1	2	3
59.	I would like to see the counselor I had before.	0	1	2	3
60.	I would like to see a doctor or nurse about medical problems.	0	1	2	3
61.	I want to receive medication.	0	1	2	3
62.	I would like my spouse or partner to be in treatment with me.	0	1	2	3
63.	I would like to have private, individual counseling.	0	1	2	3
64.	I would like to be in a group with people who are dealing with problems similar to my own.	0	1	2	3
65.	I need someone to care for my children while I am in treatment.	0	1	2	3
66.	I want my treatment to be short.	0	1	2	3
67.	I believe I will need to be in treatment for a long time.	0	1	2	3

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DASS 21

NAME ________________________ DATE __________

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all - NEVER

1 Applied to me to some degree, or some of the time - SOMETIMES

2 Applied to me to a considerable degree, or a good part of time - OFTEN

3 Applied to me very much, or most of the time - ALMOST ALWAYS

						FOR OFFICE USE		
		N	S	O	AA	D	A	S
1	I found it hard to wind down	0	1	2	3			
2	I was aware of dryness of my mouth	0	1	2	3			
3	I couldn't seem to experience any positive feeling at all	0	1	2	3			
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3			
5	I found it difficult to work up the initiative to do things	0	1	2	3			
6	I tended to over-react to situations	0	1	2	3			
7	I experienced trembling (eg, in the hands)	0	1	2	3			
8	I felt that I was using a lot of nervous energy	0	1	2	3			
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3			
10	I felt that I had nothing to look forward to	0	1	2	3			
11	I found myself getting agitated	0	1	2	3			
12	I found it difficult to relax	0	1	2	3			
13	I felt down-hearted and blue	0	1	2	3			
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3			
15	I felt I was close to panic	0	1	2	3			
16	I was unable to become enthusiastic about anything	0	1	2	3			
17	I felt I wasn't worth much as a person	0	1	2	3			
18	I felt that I was rather touchy	0	1	2	3			
19	I was aware of the action of my heart in the absence of physicalexertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3			
20	I felt scared without any good reason	0	1	2	3			
21	I felt that life was meaningless	0	1	2	3			
					TOTALS			

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Clients shall retain all rights, benefits and privileges guaranteed by the laws and Constitution of the State of Oklahoma and the United States of America, except those specifically lost through due process of law.

You have the right to be treated with respect and dignity.

You have the right to receive services in a safe, sanitary and humane environment.

You have the right to receive services in a humane psychological environment protecting you from any harm, abuse or neglect.

You have the right to receive services in an environment that provides privacy, promotes personal dignity, and provides the opportunity for you to improve your level of functioning.

You have the right to receive services without regard to your race, religion, gender, sexual orientation and gender identity, language, ethnic or national origin, age, degree of disability, handicapping condition, legal status, and any other characteristic protected under federal, state or local laws.

You have the right to not be neglected or sexually, physically, verbally, or otherwise abused.

You have the right to be provided with competent, appropriate treatment services and an individualized treatment plan. You will be afforded the opportunity to participate in your treatment and treatment planning and may agree or refuse to agree to the proposed treatment. If you allow, your family and/or significant other can be involved in the treatment and treatment planning

Your records will be treated in a confidential manner.

You have the right to request the opinion of an outside medical or psychiatric consultant at your expense.

You have the right to file a grievance if you believe any of these or other rights are violated.

You will never be retaliated against or be subject to any adverse conditions or treatment for asserting your rights.

Limits of confidentiality: Generally, without your written consent, I will not say to anyone outside of this agency that you receive services here. There are some exceptions:

- If you say you have knowledge of, or are participating in child or elder abuse or neglect.
- You say you are going to harm yourself or someone else.
- You commit a crime against this agency or anyone who is associated with this agency or threaten to commit such a crime.
- The release of information is requested by a special court order.

By signing this notice, I acknowledge that I have read, have had read to me, or have been provided a copy of this Notice of Client Rights. Any questions I had were explained to me to my satisfaction.

Client Signature: ____________________________________ Date: ___________________

Printed Client Name: ________________________________ SSN/ID: ____________________

Counselor Signature: _________________________________ Date:___________________