Jimena Isaza, LPC
2219 Sawdust Road, suite 1101
The Woodlands, TX 77380

I am honored that you have selected this practice to provide you with counseling services. I will do my best to assist you in making this experience meaningful and fruitful. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

Background Information

Working in the field of psychology since 1995, I hold a degree of M.A. in Clinical Psychology. I am a Licensed Professional Counselor, licensed by the Texas State Board of Examiners of Professional Counselors.

As a therapist I believe that I am being invited into my client's life, to walk along and to help lift the suffering for a while, in order to be able to find alternative ways to that path. I will shed light, knowledge, care and support through a journey the client has come to share with me. No one but the client is able to change the path, the attitude or the choices that have been or will be made; this is truly an individual quest. I will do the best to my abilities in understanding and guiding my clients during therapy.
I have a special interest in family dynamics and how they play a role in the client's life. I keep in mind the environment and cultural beliefs the client brings into therapy and have an utmost respect for it. Counseling is also provided in Spanish at client's request.

I am an interactive participant in therapy rather than a passive observer. I work with children, adolescents, adults, parents, couples, families, older clients, and caregivers.
Counseling techniques may include activities such as art, sand tray or drama. I may assign homework that could include videos, support groups, journaling or relaxation techniques.

Most counseling relationships will last for a limited amount of time. The client and I will decide together when goals have been met and you are comfortable with ending counseling sessions. Hopefully, your experience in counseling will have been a positive one so that if you feel the need to seek help later, you will feel safe enough to return to counseling.
It is a violation of professional ethics to enter into a counseling relationship with a client who is under the care of another licensed or certified counseling professional. If you are currently under the care of another mental health care professional, please let me know so we can discuss options. If at any time I feel the treatment needed is beyond my expertise, I will refer you to a capable source.
I can be reached at 832-671-6616 through voicemail. I will not interrupt sessions to answer phone calls. I will return calls within 24 hours.

Fees

The individual adult, child or adolescent initial intake session will be 75 minutes long. The initial intake fee is $150. Each subsequent session will be 45-50 minutes long. The fee for these sessions will be $125 payable at each session. An initial intake session for couples will be 90 minutes long. The initial intake fee is $180. Each subsequent

session will be 75 minutes long. The fee for these sessions will be $150 payable at each session. All fees for services are due at the time service is rendered.

Cancellations

At least 24 hours advanced notice for cancellations is appreciated. With the exception of serious illness, cancelling sessions with less than 24 hours notice will result in client being charged for the missed session.

A $35 charge will be due for all returned checks. I accept all major credit cards. I will provide a receipt upon request for third party reimbursement. Any and all costs incurred for recovering fees will also be the responsibility of the client. If you are late for a session, you will be given the remainder of your session. You are financially responsible for the full session.

Confidentiality

The very nature of counseling is based on a sense of safety. This safety is often founded on client/counselor confidentiality. It is my responsibility to keep all information concerning my clients confidential.

The limits to this are if;

- I have reason to believe my client is a danger to themselves or others.
- I find that my client seeks treatment to avoid detection or apprehension or enable anyone to commit a crime.
- I was appointed by the court system to evaluate my client.
- I find that my client has contacted this counselor for the purpose of determining sanity in a criminal proceeding.
- I find you contact this counselor for the purpose of establishing competence.
- If this counselor is expected to file a report to a public employer or, as to information required to be recorded in a public office, if such a record is open to public inspection.
- If my client is under the age of 16 and the victim of a crime.
- I have reason to believe my client is involved in, is a victim of, or has knowledge about abuse or neglect of a child, disabled person and/or an elderly person, or anyone who is incapable of taking care of themselves.
- My client dies and the communication is important to decide an issue concerning a deed of conveyance, will or other writing executed by my client affecting as interest in property.
- If my client filed suit against this counselor for breech of duty, or this counselor's suit against a client.
- My client has filed suit against anyone and claim mental/emotional damages as part of the lawsuit.
- I am legally compelled by a judge to testify in court or my records are subpoenaed or court ordered.
- Should you want me to acknowledge you as a client or disclose information to any person; a written consent form must be signed prior to release of information.
- If there has been sexual abuse or exploitation by a previous counselor.
- If my client's insurance company requires information in order to release payment.

- Other reasons as specified by law.

If I see you in public, I will protect your confidentiality by not acknowledging or approaching you first. I will not discuss your case in any public place. You are in control of the counseling relationship. You have the right to end the relationship at any time. Please let me know if at any time you are dissatisfied with my services. If I am unable to resolve your concerns, I will assist you in finding another counselor with whom you might be able to work more effectively.

Counseling your Child or Adolescent

As a parent or guardian, you will naturally be curious about what happens in counseling sessions with your child. It is important that your child or adolescent feel safe and able to trust the counseling relationship. It is my policy to maintain confidentiality with your child or adolescent while keeping you updated on your child's progress. I ask you to remember that as a professional, if at any time I feel your child or adolescent is in serious danger, I will break confidentiality to share information with you and the proper authorities if necessary in order to keep your child or adolescent safe. I will inform the client before breaking confidentiality if possible.
When you bring your child for counseling, it is imperative that you stay in the building during the session. I must be able to find you in case of emergency.

Your signature below indicates you have read (or have had explained), understand and agree to this agreement. Having read the policies described in this packet, you agree to all professional policies and agree to meet all financial obligations.

_____ _____
Client signature Date

_____ _____
Parent or guardian signature Date

_____ _____
Counselor signature Date

If you have any complaints about my service to you, I invite you to discuss them with me at once. This process may enhance the counseling process as well as your progress. If you would like to make a formal complaint, please contact:

Texas State Board of Examiners of Professional Counselors
Complaints management and Investigative Section
P. O. Box 141369
Austin, Texas 78714-1369
(512) 834-6658

INFORMED CONSENT

I acknowledge I have read, (or have had read to me), received, and understand the Professional disclosure Statement, the Informed Consent and the Intake Form. I have had all my questions answered fully. I do hereby seek and consent to take part in treatment with Jimena Isaza, M.A., LPC. I understand that developing goals and a treatment plan with this counselor and regularly reviewing our work will be in my best interest. I agree to play an active role in the process. I understand that no promises have been made or will be made as to results of any treatment or any procedures provided by the counselor. I understand that Ms. Isaza will maintain my confidentiality with the exception of the ethical limits of confidentiality set forth in the Professional Disclosure Statement. I understand that Ms. Isaza may consult with colleagues in reference to my case in order to better serve me. This could involve digital recordings. I will be informed prior to any recordings and will have the right to refuse to be recorded. I am aware that I may stop treatment with this counselor at any time. I will still be financially responsible for payment for past scheduled sessions if payment is not current. I am aware that I may loose other services or may have to deal with other consequences if I stop treatment with this counselor, (EX: if treatment is court ordered, I will have to answer to the court.) I know I must call to reschedule or cancel an appointment at least 24 hours in advance. If I do not reschedule, cancel or show up for an appointment, I will be charged for the full appointment.

My signature below confirms that I understand and agree with all these statements.

_____ _____

Client signature Date

_____ _____

Parent or guardian signature Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The privacy of your mental health information is critically important. This Notice will inform you about the ways I use and share mental health information about you. I will also describe your rights and certain duties I have regarding the use and disclosure of your protected mental health information. The term "information" in this Notice includes any personal information that is created or received by a healthcare provider that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

How I Use or Disclose Information:

I must use and disclose your mental health information to provide information:

1. To you or someone who has the legal right to act for you;
2. To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
3. Where required by law.

I have the right to use and disclose mental health information to pay for your health care and operate my business. For example, I may use your health information:

1. For payment of premiums due and to process claims for services you receive.
2. For treatment, I may disclose mental health information to your providers or provider facilities to help them provide care to you.
3. For health care operations, I may use or disclose mental health information as necessary to operate and manage my business and to help manage your health care coverage. For example, I may speak with your provider to suggest a wellness program that could help improve your mental health.

I may use or disclose your mental health information for the following purposes under limited circumstances:

1. To persons involved with your care: I may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
2. For reporting victims of abuse, neglect, or domestic violence to government authorities, including a social service or protective agency.
3. For health oversight activities, such as governmental audits and fraud and abuse investigations.
4. For judicial or administrative proceedings, such as in response to a court order, search warrant, or subpoena.
5. For law enforcement purposes such as providing limited information to locate a missing person.
6. To avoid serious threat to health or safety by, for example, disclosing information to public health agencies.
7. For specialized government functions such as military and veteran activity, national security and intelligence activities, and the protective services for the President and others.

What are your rights?

The following are your rights with respect to your mental health information:

1. You have the right to ask to restrict uses or disclosures of your mental health information for treatment, payment, or health care operation. You have the right to also ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. Please note that while I will try to honor your request and will permit requests consistent with my policies, I am not required to agree to any restriction.
2. You have the right to ask to receive confidential communications of information in a different manner or at a different place (for example: by sending it to a P.O. Box rather than your home address).
3. You have the right to see and obtain a copy of your mental health information that may be used to make decisions about you such as claims and case or care management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, I may deny your request to inspect and copy your mental health information if I believe that disclosure of certain information contained in your mental health records may be harmful to your condition or impede further treatment of your condition. This decision will be binding.
4. You have the right to amend information I maintain about you if you believe the mental health information about you is wrong or incomplete. If I deny your request, you may have a statement of your disagreement added to your mental health information.
5. You may have the right to receive an accounting of disclosures of your information made by me during the six years prior to your request.
6. You have the right to a paper copy of this Notice. You may ask for a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.
7. If you believe that your rights have been violated, you may notify the Secretary of the U.S. Department of Health and Human Services if you have any complaint to make. I will not take any action against you for filing a complaint.

I have received a copy of this Notice and understand its meanings and implications.

Client's name (printed): _____

Client's (or guardian's) signature: _____

Date: _____

INTAKE ASSESSMENT FORM

Date _____

Name of Patient_____ Date of birth _____

Address: _____

Phone: _____ Email: _____

Current Concerns:

What concern brings you in?

_____
_____
_____

When did this concern begin (give dates)?

_____
_____
_____

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern:

_____
_____
_____

Are you having any difficulties/stressors in your current job / at home / at school? If so, please briefly describe those difficulties.

_____
_____
_____

What do you hope to accomplish in counseling?

_____
_____
_____

What kind of obstacles could get in the way?

_____

How much does this problem impact your current daily activities, job performance and/or academic progress? (Circle One)

1	2	3	4	5
Not at All	A little bit	Moderately	Quite a bit	Extremely

Have you been in therapy before or received any prior professional assistance for your concerns (Therapist, Psychiatrist, Physician)? If so, please give dates of treatments and results:

_____

_____

Feelings – circle any of the following feelings that apply to you:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Others:	

Physical – circle any of the following symptoms that apply to you:

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Dry mouth	Palpitations	Fatigue	Burning or itchy skin	Muscle spasms
Twitches	Chest pains	Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling	Watery eyes

Behavior – circle any of the following behaviors that apply to you:

Overeat	Suicidal attempts	Can't keep a job	Take drugs	Compulsions
Insomnia	Vomiting	Smoke	Take too many risks	Odd behavior
Withdrawal	Lack of motivation	Drink too much	Nervous tics	Eating problems
Work too hard	Procrastination	Sleep disturbance	Crying	Impulsive reactions
Phobic avoidance	Outbursts of temper	Loss of control	Aggressive behavior	Concentration difficulties

Medical History
Name of Physician: _____
Please list any significant past or current health, medical, or psychiatric issues (including anything resulting in hospitalizations).

Dates, Problem & Treatment Were you hospitalized (Y/N)
_____
_____
_____

Medications or Substance Abuse
If applicable, please list all medications you are now taking or have taken in the past three months, including birth control pills, vitamins, herbs and supplements.
Medication Dosage Person prescribing. How long have you been taking this? Helpful (Y/N)
_____
_____
_____
_____

If applicable, number of cigarettes smoked per day:_____
If applicable, amount of alcoholic beverages per day: _____
Type of beverage:_____

Family History (include spouse, significant other, children, parents, step families, adoption history, etc.)

Name	Relationship	Age	Living where?

Marital status of patient

Married ____ How long_____
Divorced ____ How long ago _____
Separated ____ How long ago _____
Widow/widower____ How long ago _____
Other _____

Other significant adults or children in patient's life (Please include type of Relationship -e.g. supportive, conflictual, etc.)

_____
_____
_____

Relationship issues

Are you currently dating? _____ at what age was your first date? _____
Are you sexually active? _____
Would you consider yourself to be heterosexual / homosexual / bi-sexual _____
_____
Would you describe yourself as timid or as social (easily makes friends and participates in social functions)

_____
_____

Traumatizing Life Events

Have you experienced any history of significant abuse (physical, emotional or sexual)?
Please briefly describe _____

_____
_____
_____

Any **history of significant life events** such as deaths, separation from parent(s), frequent moves, terminal illnesses in the family or close friendship?

_____
_____
_____
_____

Cultural Influences

With what ethnic/cultural groups do you personally identify? _____
With what ethnic/cultural group does your family most identify? _____
Describe any cultural values or beliefs that may impact treatment _____
_____

Educational History *(If applicable)*

Highest degree earned_____
Current School attending_____ Grade_____
Average grade performance _____
Overall motivation to attend school _____
Extracurricular activities_____

Employment History *(If applicable)*

Present employment status-where-how long? _____

Positive/negative aspects of current position _____
_____

If on leave of absence or disability, will you return to present job? _____
_____

Special interests/hobbies/skills
_____
_____
_____

Additional Comments _____
_____
_____
_____
_____
_____

_____ _____
Signature Date