Lauren E Thompson LPC, PLLC

3033 NW 63rd Street, Suite 160 East
Oklahoma City, OK 73116
(405) 410-7602

CLIENT BACKGROUND INFORMATION

Last Name: _____ First Name: _____ MI: ____

Preferred Name: _____DOB: ___/___/___ Age: ____ Gender: _____

Relationship Status: _____

Address: _____ City: _____ State: ____ Zip: _____

Preferred Phone:_____ E-mail: _____

Can we can leave a message on your phone: ☐ Yes ☐ No

EMERGENCY CONTACT (If client is under 18 or under legal guardianship, list Parent/Guardian)

Last Name: _____ First Name: _____

Contact Number:_____ Relationship: _____

HEALTH INSURANCE INFORMATION

Insurance Company: _____

Policy Number: _____ Group Number:_____ Effective Date:_____

Policy Holder (cite name as is appears on the insurance card): _____

Policy Holder Date of Birth: _____ Policy Holder Place of Employment: _____

Policy Holder Address: _____ City: _____ State: _____ Zip: _____

Policy Holder Phone Number: _____

CURRENT LIVING SITUATION & FAMILY HISTORY

I live: ☐ Alone ☐ w/Significant Other ☐ w/ Others Number of Persons in Home:_____

Do you have children living IN HOME? Yes _____ No _____

Names, Ages, Gender: _____

_____

Do you have children living OUTSIDE OF HOME? Yes _____ No _____

Names, Ages, Gender: _____

_____

Do you have non family members LIVING IN HOME? Yes _____ No _____

Name: _____ Relationship to Client: _____

Name: _____ Relationship to Client: _____

PRESENTING PROBLEM/HISTORY OF PRESENTING PROBLEM

Who referred you? _____

Please briefly describe the reason for seeking counseling:

_____

_____

_____

Please check your employment status ☐ Full-time ☐Part-Time ☐Unemployed ☐Not in Labor Force

If employed, who is your employer? _____

Are you currently enrolled in school? ☐ Yes ☐ No If so, where? _____

Highest level of education (grade) completed: _____

Have you served in the military? ☐ Yes ☐ No If so, what is your current status? _____

Are you currently using tobacco products? ☐ Yes ☐ No

If yes, please describe your use: _____

Are you currently using alcohol? ☐ Yes ☐ No

If yes, please describe your use: _____

Are you currently using other substances? ☐ Yes ☐ No

If yes, please describe your use: _____

Have you been arrested in the past 12 months? ☐ Yes ☐ No

If yes, what are your charges? _____

Have you ever experienced physical, emotional, verbal or sexual abuse, sexual misconduct or neglect?

☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, identify month & year of attempt(s): _____

Have you ever had thoughts of suicide? ☐ Yes ☐ No

If yes, identify month & year of latest thought(s):_____

Have you ever been involved in domestic violence? ☐ Yes ☐ No

Have you ever been told you have an anger problem? ☐ Yes ☐ No

MEDICAL

Are you currently under the care of a physician for medical problems/medication? ☐ Yes ☐ No

Could these medical problems/medication impact your mental health treatment? ☐ Yes ☐ No

Physician Name: _____ Phone: _____

Are you currently under the care of a Psychiatrist? ☐ Yes ☐ No

If yes, Psychiatrist Name: _____Phone: _____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, list those you are currently taking (use back if needed):

	Medication	Strength & Dosage	Length Taken	Purpose & Side Effects
1.				
2.				
3.				

Are you currently receiving behavioral/mental health services elsewhere? ☐ Yes ☐ No

If yes, where: _____

Have you received behavioral/mental health services in the past? ☐ Yes ☐ No

If yes, provide the following (use back if needed):

Date	Type*	Where	Purpose/Diagnosis

Please include any other information you feel is important for therapist to know.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Client Signature Date

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Consent For Treatment

Statement of Professional Disclosure

You may access the laws and regulations which govern Licensed Professional Counselors at the following website:
LPC: http://www.ok.gov/health/Protective_Health/Professional_Counselor_Licensing_Division/index.html

Rights as a Client

Counseling services are voluntary. By signing this form you acknowledge and are consenting to receive services necessary for yourself, your child and/or family, including diagnosis and treatment. Your consent to receive services does not waive your legal rights as recognized under Oklahoma law. Our conversations and your records are confidential. If you are consenting for a minor, you state that you are said minor's parent and/or legal guardian.

Information obtained and discussed during session is *confidential*. Confidentiality **will be broken** for the following reasons:

- You give your written permission on a release of information form.
- A court orders me to disclose records.
- A legal guardian gives written permission to release the information of a minor child.
- In an emergency situation when your personal safety or the safety of others may be threatened (Duty to Warn).
- There is a suspicion or report of abuse or neglect of children, elderly or disabled persons.

You have a right to review all written reports about our work before they are sent/released.

It is further understood that in order to file health insurance claims, your health insurance provider may request records (e.g.) treatment plans or session notes in order to verify services and to assure the quality of services being provided. You will be informed when these circumstances occur. You have a right and responsibility to review these documents.

You may request that I communicate with your Primary Care Provider or psychiatrist regarding evaluation and treatment information by signing a release of information form. Upon request that your records be sent to another professional or agency, your wishes will be fulfilled with promptness upon receipt of your written request for information and provided there is no outstanding balance on your account.

Requested records may be protected under 42 C.F.R. Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts. 160 & 164, State Confidentiality laws and regulations and cannot be released without your consent unless otherwise provided for by regulations. State and Federal law regulations prohibit any further disclosure of such records without your specific written consent or when otherwise permitted by such regulation.

As a client, you have the right to leave the premises at any time. You are not to be detained against your wishes unless you are a danger to yourself or others, or if I suspect you are under the influence of alcohol or drugs.

You have the right to refuse any service which you do not want and to discontinue any services you have already started. However, if you choose to discontinue treatment against professional advice, a notation to that effect will be placed in your records. In the event of court-ordered clients, the terms of the court may supersede this right.

Client Name_____

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It is the policy of Lauren E Thompson LPC PLLC to treat all clients and not to discriminate with regard to race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression or disability.

Lauren E Thompson LPC, PLLC is **not** an emergency service and does **not** provide 24 hour care. Therefore, in the event of an emergency, you agree to call 911 or go to your nearest emergency room. The Oklahoma County Crisis Line is (405) 522-8100.

I may participate in peer consultation with other providers to assure services are appropriate and beneficial to you and/or your family.

Confidentiality of Electronic Communications

Confidentiality of Electronic Communications includes, but is not limited to: E-mail, Text, and Cell Phone Communication. If you choose to e-mail your therapist, it is preferred that you do so by setting up an account via therapyappointment.com, which is encrypted and HIPAA compliant. Please call your therapist to set up your login. Please limit the contents of your e-mail to basic issues such as cancellation or change in contact information. Your therapist will not respond to personal and clinical concerns via e-mail or text. If you call your therapist, please be aware that unless you are both on landline phones, the conversation is not confidential. Likewise, text messages are not confidential. **Please take note that Lauren E Thompson LPC, PLLC cannot guarantee confidentiality if you choose to email from your personal account or call or text from a cellular phone.**

Legal Issues, Court Reports and Testimony

If you are currently involved in a legal dispute involving custody, visitation, DHS or other court related issues you are required to disclose said involvement at the initial counseling appointment. As a counselor the regulations and code of ethics under which I practice my profession specifically describe how I legally may or may not conduct my services in matters involving legal decisions. Under the LPC Acts & Regulations I **cannot** be used as an expert witness for any forensic purposes. As your counselor, I am only able to serve as a "fact" witness in any legal report, deposition or testimony. A "fact" witness entails providing only factual information about services you received, and only when the client and/or legal guardian gives her/his written permission to waive confidentiality. Waivers of privilege/ confidentiality must describe what specific information is to be released, to whom, for what purpose and for how long the release is valid. As a factual witness and under the LPC Acts & Regulations **I cannot give any opinions, recommendations or conclusions**.

I will charge a fee for report writing, telephone consultations with attorneys, depositions, court appearance and testimony. I will provide clients with a fee schedule that details the amount charged for these services.

Counseling of a Minor

Parents or legal guardians are encouraged to actively participate in counseling for their minor child. A parent or legal guardian must consent for services for their minor child.

In order to provide counseling services for a minor with divorced or legally separated parents/legal guardians, **both parties** must consent in writing to said counseling services; unless legal documentation is provided that states one party may consent without the other. Parents/legal guardians must provide legal documentation showing custody of the minor child.

Client Name_____

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Attendance & Appointment Reminders

Your appointment time is reserved for you; and 24 hours' notice is required to cancel your appointment. This allows time to refill your time slot. Same day cancellation/no show fees will apply if 24 hours' notice is not given (see financial agreement). Excessive appointment cancellations/no shows may result in the termination of services.

If you choose, an automated appointment reminder will be sent to you one day prior to your scheduled appointment. Appointment reminders are not guaranteed. If you do not receive an appointment reminder and fail to attend your scheduled appointment, missed appointment fees still apply. Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted below.

I would like to receive ONE appointment reminder via:

- Text message to this cell phone number: _____
- Email message to this email address: _____
- Automated telephone message to this phone number: _____

I have read the Consent for Treatment form in its entirety and agree to the terms of consent. I understand and agree to the limits of confidentiality and conditions of therapy

Client Signature _____ Date _____

Client Signature _____ Date _____

Parent/ Guardian Signature _____ Date _____

Witness _____ Date _____

Client Name _____

Lauren E. Thompson, PLLC

Licensed Professional Counselor

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Teletherapy Consent Form

Teletherapy is the delivery of psychological services provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications via a HIPPA compliant secure system. Teletherapy has the same purpose as traditional face to face psychotherapy sessions. However, due to the nature of the technology used, teletherapy may be experienced somewhat differently than face-to-face treatment sessions. I understand that I have the following rights with respect to teletherapy:

Client's Rights, Risks, and Responsibilities

1. I am a legal resident of Oklahoma.
2. I understand that teletherapy involves the transmission of my medical/mental health information, both orally and/or visually via audio/visual HIPPA compliant systems.
3. I have the right to withhold or withdraw consent for teletherapy at any time without affecting my right to future care or treatment.
4. The laws that protect the confidentiality of my medical information also apply to teletherapy. I understand that the information disclosed by me during the course of my teletherapy sessions is confidential. However, the mandatory exceptions to confidentiality, which are described in the general consent form that I received at the beginning of treatment with Lauren Thompson, also apply to teletherapy.
5. I understand that there are risks of participating in teletherapy. These include but not limited to, the possibility that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
6. I understand that teletherapy based services may not be as complete as face-to-face services.
7. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I agree to call 911 or go to the nearest hospital emergency room.
8. I, the client, am responsible for providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. I also understand that there is a risk of being overheard by anyone near me if I am not in a private room or environment while participating in teletherapy, and that securing a private environment is my responsibility. It is the responsibility of Lauren Thompson to do the same on her end.
9. I understand that I am responsible for verifying if my insurance company covers teletherapy, and that I am responsible for any amounts not covered. I understand that the same fees apply to teletherapy sessions as apply to in office sessions. This includes no show, late cancellations etc., as outlined in the initial financial agreement. I agree to keep a credit card on file with Lauren Thompson to utilize teletherapy services.
10. I agree that I will not photograph or record any teletherapy sessions without prior written consent from Lauren Thompson, LPC.

I have read the Consent for Teletherapy form in its entirety and agree to the terms of consent. I understand and agree to the limits of confidentiality and the conditions of teletherapy.

Client Signature _____ Date _____

Parent/ Guardian Signature _____ Date _____

Client Name: _____ Revised 03/20

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ...
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 ____

2. Did a parent or other adult in the household **often** ...
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 ____

3. Did an adult or person at least 5 years older than you **ever**...
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 ____

4. Did you **often** feel that ...
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 ____

5. Did you **often** feel that ...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 ____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 ____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 ____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 ____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 ____

10. Did a household member go to prison?
    Yes No If yes enter 1 ____

Now add up your "Yes" answers: This is your ACE Score TOTAL ____

Licensed Behavioral Practitioners
Licensed Marital and Family Therapists
Licensed Professional Counselors

State Board of Behavioral Health Licensure
3815 N. Santa Fe, Ste. 110
Oklahoma City, OK 73118
Telephone: (405) 522-3696
Fax: (405) 522-3691
www.ok.gov/behavioralhealth

STATEMENT OF PROFESSIONAL DISCLOSURE

Please check the appropriate license: ☑ LPC ☐ LBP

I am required by law to furnish this document to you. It requires that I inform you about my professional training, orientation /techniques, experience, fees and credentials. I am licensed to practice my profession by the State Board of Behavioral Health Licensure.

My license number is **LPC** 4820 **LBP** _____

The licensing website is **www.ok.gov/behavioralhealth** where you can access the law and regulations which govern my license. I will furnish you with printed materials about the requirements of my licensure if you so desire. You may contact (without giving your name), the State Board of Behavioral Health Licensure at:

State Board of Behavioral Health Licensure
3815 N. Santa Fe, Ste. 110
Oklahoma City, OK 73118
Telephone: (405) 522-3696
www.ok.gov/behavioralhealth

Licensee's Printed Name: Lauren Thompson

Licensee's Signature: _____ **Date:** 9/4/2018

The above-designated licensee has satisfactorily supplied me with information regarding his/her practice, licensure and professional development.

Client's Signature: _____ **Date:** _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgment.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (please provide specific details) _____

_____

_____ _____
Employee Signature Date