Staci Lea Rocha, M.A., LPC

Client Information

Please fill out each section on this form.

If a section does not apply, please write N/A over that section. Thank you

Date: _____

Client Name: _____ DOB: _____
Gender: M F Phone: © _____ (h): _____ (W): _____

Address _____ Employer: _____
_____
_____ SS#: _____
DL State & # _____

Name/Address/Phone # of Nearest Relative not living with you:
_____

Marital Status: _____ Spouse's Name: _____

Who referred you to this office? _____

Billing Information:

Responsible Party: _____
Address: _____
Phone: _____ Alternate Phone: _____

Release of Information

Your privacy is important to me and I want to protect your personal health information. Please initial to whom I may release information. You have the right to revoke this permission at anytime by communicating your desire in writing.

_____ my physician, please identify: _____
_____ my spouse, please identify: _____
_____ my family, please identify: _____
_____ my attorney, please identify: _____
_____ my children, please identify: _____

Client Information

I prefer to be contacted using the following methods: (check all that apply)

_____ Home Telephone: _____
_____ Acceptable to leave a detailed message
_____ Leave message with call back number only
_____ Acceptable to fax to this number
_____ Written Communication
_____ Acceptable to mail to home (ie Birthday/Christmas Card)
_____ Acceptable to mail to office/work
_____ Work Telephone: _____
_____ Acceptable to leave a detailed message
_____ Leave message with call back number only
_____ Cell Phone: _____
_____ Acceptable to leave a detailed message
_____ Leave message with call back number only

_____ _____
Client or Responsible Party Date

Statement of Understanding
Regarding Charges for Mental Health Services

I am the person responsible for payment for mental health services rendered by Staci Rocha MA LPC to _____. With the exception of payments made by or due from insurance that covers mental health services, I understand that my part of the bill for these services is in default 30 days after the services are rendered. When insurance refuses to cover these charges, the bill is in default 30 days after the insurance declares the bill to not be covered by insurance.

I understand and agree that I shall be liable for all and all collection expenses should my bill for mental health services come into defaults.

_____ _____
Client or Responsible Party Date

_____ _____
Print Name Date of Birth

Staci Rocha, M.A., LPC
4601 50th St Suite 203
Lubbock, Texas 79414

Phone: (806) 787-0701 **Fax: (806) 701-5899**

IMPORTANT INFORMATION AND CLIENT CONSENT FORM

Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and I have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. I can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor are any sort of trade of service for service.

AVAILABLE SERVICES: Staci Lea Rocha MA, LPC offers a wide array of counseling services, including individual, family, couples, and group services. I am a skilled and experienced licensed professional counselor. Effective psychotherapy is founded on mutual understanding and good rapport between you, the client, and I. It is my intent to convey the policies and procedures used in my practice, and I will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues, which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: I provide short-term counseling designed to address many of the issues my clients are dealing with. Your first visit will be an assessment session in which you and I will discuss your concerns, and if both parties agree that I can meet your therapeutic needs, we will develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you, services to you may be terminated.

The goal is to provide the most effective therapeutic experience available to you. If at any time you feel that you and I are not a good fit, please discuss this matter with me to determine if transferring to a more suitable therapist is right for you. If you and I decide that other services would be more appropriate, I will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. My services are designed to provide my clients with an integrated solution for their mind, body, spirit, and life, to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are 45 – 55 minutes long depending on your insurance coverage. The allotted time includes counseling, payment, and the scheduling of our next appointment. More frequent sessions or an intensive outpatient schedule are available if I determined it is appropriate.

PHONE CALLS: If you need to get in touch with me, please call 806.787.0701. If you are unable to reach me by phone, and you are in a crisis situation, please call 911 or go to the nearest hospital for treatment. If your call is not an emergency, feel free to leave a message and contact number, as my voice mail is confidential. I retrieve all messages personally.

CANCELLATION/RESCHEDULE: If you must cancel or reschedule your appointment, we ask that you call our office at 806.787.0701 at least 24 hours in advance. This will free your appointment time for another client. **The full session fee will be required for any cancellation/reschedule not made prior to the 24-hour time frame.**

MISSED APPOINTMENTS: Failure to keep a scheduled appointment that was not cancelled or rescheduled prior to the 24-hour window is considered a "No Show". No Shows will be charged **the full session fee**

FEE SCHEDULE:	Diagnostic & Evaluation Session (1st visit)	$ 135.00
	Regular Office Visits (Standard Counseling Hour) (Individuals, Couples, family)	$ 135.00
	Psychological or Educational Testing	Varies by Test
	Written Reports (insurance, employers, etc. pro-rated at)	$50.00/report
	Returned check fee per check	$ 25.00

A reasonable fee will be charged for copies of any records requested by the Client.

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the beginning of each session. This will allow the maximum amount of time to be spent on counseling and not on the payment. I accept payment in the form of cash, check, debit or credit. When using checks, make them payable to Staci L. Rocha, LPC. All checks that are returned for insufficient funds will be charged an additional $25.00 bank and handling fee.

If you are using insurance benefits, my office will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered.

OVERDUE ACCOUNTS: Payments not received within 30 days are charged a late fee of $5.00 per month. If payment is not received within 90 days, or monthly payments are not made as agreed, Staci L. Rocha, LPC will submit the account to the small claims court. The patient or responsible party is responsible for the charges incurred to collect the balance of the account.

EMERGENCIES: In the event you encounter a personal emergency that will require prompt attention, please contact my office regarding the nature and urgency of the circumstances. Either my office manager or I will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, please call my main number and leave a confidential voice mail. Please utilize this option in the event of a serious crisis, and I will call you back as soon as possible. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When I am out of town, you will be advised and given the name of an on-call Therapist.

COURT APPEARANCE: I do not testify in court. If you are seeking services for this purpose please seek mental health providers that can provide this service.

SOCIAL MEDIA: I do not accept friend requests from current or former clients. This holds true for Facebook, LinkedIn, or any other networking sites. My reasons for this stance are that I believe that adding clients as friends can compromise confidentiality and blur the boundaries of our therapeutic relationship. If you have questions about this, please feel free to bring it up in session.

ELECTRONIC COMMUNICATION: Although they add convenience and expedite communication, it is very important to be aware that communication by any electronic means of communication (Texting via Cell Phones, Computers, e-mail, Texting via other methods, etc.) can be accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited access to all e-mails that

go through them. Therefore, if you are going to send me confidential information, I suggest you send it to me via encrypted-email. We can discuss and set a unique password during session.

Text messages are not encrypted. Although this form of electronic communication is great for cancellations and reschedules, I prefer you contact my office via a telephone call.

If you communicate confidential or private information via any electronic communication, I will assume that you have made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted.

Please do not use e-mail or faxes for emergencies. These forms of communication are not real-time and I may not check my e-mails or faxes daily. Also, due to potential computer, network, or fax machines/line problems, your e-mail or fax may not be deliverable.

If e-mail communication outside of therapy requires more than 5 minutes to read or respond to, I may charge for my full professional fee. Please indicate if you intend to pay these charges in your e-mail, or I will save it for review during your next session. Please do not send forwarded messages regardless of how inspirational they may seem to my professional e-mail address. I use this for work related issues and do not want to risk viruses spread by forwarded e-mails.

CONFIDENTIALITY: I follow all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention and we will discuss this matter further. By signing this Information and Consent Form, you are giving me consent to share confidential information with all persons mandated by law and with the agency that referred you, the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding me harmless from any departure from your right of confidentiality that may result.

RECORDS: Your file is kept under my locked personal supervision. Your file includes your intake form, case notes of each session, this contract, any testing results, copies of claims filed along with their EOB, and any other written communications you might give me. State and Federal (HIPAA) laws will dictate all record protection.

DUTY TO WARN/DUTY TO PROTECT: If Staci L. Rocha, LPC believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to Staci L. Rocha, LPC to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to Staci L. Rocha, LPC to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name _____ Telephone Number _____

_____ _____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of Staci L. Rocha, LPC, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by Staci L. Rocha, LPC, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

In the event of my death or incapacitation, you will be able to request your records through this office. My office manager will be glad to send them to your next provider. In the event of the death of my office manager, Staci Rocha, LPC will submit your records to your next provider. She can be reached at 806.787.0701.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. **NOTE**: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment Staci L. Rocha, LPC will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

LEGAL AGREEMENTS: Do you have a divorce, custody or visitation agreement in place? If there are any legal judgments a copy of the forms are REQUIRED to be provided to Staci Rocha MA LPC PRIOR to receiving services. If a judgment is in process then a copy is REQUIRED immediately following the court date.

_____ _____

Signature – Client (Parent/Guardian Signs below if under 18) Date

_____ _____

Signature – Spouse/Partner/Parent/Guardian Date

_____ _____

Therapist Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____ _____

Client (Client's Parent/Guardian if under 18) Date

I authorize the payment of medical benefits to the provider of services.

_____ _____

Client (Client's Parent/Guardian if under 18) Date

Staci Lea Rocha, M.A., LPC
4601 50th St Suite 203
Lubbock, Texas 79414

Phone: (806) 787-0701 **Fax: (806) 701-5899**

PERMISSION, UNDERSTANDING, AND ACKNOWLEDGEMENT

Permission to Treat:

1. By my signature below, I _____ give permission to Staci Rocha MA LPC to treat/evaluate myself, or if applicable, my dependent named _____.

Understanding of Client's Rights & Office Policies:

1. With regard to the office of Staci L. Rocha, LPC, I acknowledge I have read and understand the following documents, have been offered a copy, and can ask questions at any time.
    a. Notice of Privacy Practices
    b. What to Expect From your Licensed Professional Counselor
    c. Limits of Confidentiality
    d. Cancellation Policy

2. With regard to the office of Staci L. Rocha, LPC, I understand all policies regarding: Ethics; Confidentiality; Cancellations & Missed Appointments; and Release of Records discussed in the above documents.

_____ _____
Signature - Client (Client's Parent/Guardian if under 18) Date

_____ _____
Staci L. Rocha MA LPC Date

Cancellation/Reschedule, Missed Appointments & Fees

1. CANCELLATION/RESCHEDULE: If you must cancel or reschedule your appointment, I ask that you call the office at 806.787.0701 minimally 24 hours in advance. This will free your appointment time for another client. **The $50 fee will be required for any cancellation/reschedule not made prior to the 24-hour time frame (listed below)**

_____ _____

Client Signature **Date**

2. MISSED APPOINTMENTS: Failure to keep a scheduled appointment that was not cancelled or rescheduled prior to the 24-hour window is considered a "No Show". No Shows will be charged **a $50 fee.**

_____ _____

Client Signature **Date**

3. FEE SCHEDULE: Diagnostic & Evaluation Session & Regular Office Visits
(Individuals, Couples, Family) $ 135.00

Written Reports $ 50.00/report
Returned check fee per check $ 25.00

A reasonable fee will be charged for copies of any records requested by the Client.

_____ _____

Client Signature **Date**

4. CREDIT/DEBIT CARD TRANSACTIONS: As a convenience to clients, I accept credit/debit cards. If card is declined an alternate form of payment will need to be provided.

_____ _____

Client Signature **Date**

5. EAP (Employee Assistance Plan) or Victims Assistance Clients: If you are using EAP or Victims Assistance approved visits but cancel/reschedule (less than 24 hours) or miss an appointment, the $50/fee will be billed directly **to you**. Insurance, EAP and Victims Assistance services does NOT cover cancelled or missed appointments

_____ _____

Client Signature **Date**

Staci Lea Rocha, M.A., LPC 4601 50th St Suite 203 Lubbock, Texas 79414
Phone: (806) 787-0701 Fax: (806) 701-5899

Staci Lea Rocha, M.A., LPC
4601 50th St Suite 203
Lubbock, Texas 79414

Phone: (806) 787-0701 **Fax: (806) 701-5899**

CARD AUTHORIZATION FORM

CLIENT NAME:_____

DATE OF BIRTH:_____

The purpose of this form is to authorize Staci L. Rocha, LPC to retain a valid credit card number on file for you as our client. All new clients are required to complete this form. This form will be kept confidential and only authorized staff will have access to the information.

Your supplied credit care will be charged ONLY under the following circumstances:

1. Staci L. Rocha, LPC reserves the right to charge the credit card listed below for all current clients balances, including co-pays (following insurance payments) and a receipt will be kept in your client chart, unless directed to send the receipt directly to you. This notice serves as your consent to being charged for all current client balances on your account.

2. If you, as the client, miss a scheduled appointment without 24-hour notice to cancel or Reschedule or a no show Staci L. Rocha, LPC reserves the right to charge the credit card listed below $50 fee. This notice serves as your consent to being charged for any and all no-shows.

3. If we receive notice that a payment is returned to us for any reason, Staci L. Rocha, LPC reserves the right to charge the credit card listed below a $25.00 returned check fee as well as the amount of the issued insufficient check. A receipt will be sent to the current address on file. This notice serves as your consent to being charged for any returned payments.

4. Other than the conditions mentioned above, under NO circumstance will Staci L. Rocha, LPC charge your credit card for anything not discussed personally with you. In conjunction with HIPAA regulations, all credit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed & Accepted:

Having read this form and talked with Staci L. Rocha, LPC, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information (top of pg 2) for my credit card to be charged accordingly for the conditions listed above.

X_____ _____
Client or Responsible Party - Signature Date

X_____ _____
Counselor Signature Date

Staci Lea Rocha, M.A., LPC
4601 50th St Suite 203
Lubbock, Texas 79414

Phone: (806) 787-0701 **Fax: (806) 701-5899**

CARD AUTHORIZATION FORM

NAME, AS IT APPEARS ON CREDIT CARD:_____

CREDIT/DEBIT: _____

BILLING ADDRESS: _____

_____

AMEX/DISC/MC/VISA CARD#: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

EXPIRATION DATE: _____/_____

VERIFICATION CODE (3 or 4 DIGITS): ___ ___ ___ ___

Refusal to Complete Authorization:

Refusal to complete and agree to this authorization dictates the following:

Since there is no credit card on file, Staci L. Rocha, LPC reserves the right to send only ONE statement to the address on file to notify you of your balance with our practice. It is your responsibility to send the amount due within 30 days of your statement to avoid being sent to collections and having your account closed with our practice.

X_____ _____
Client or Responsible Party - Signature Date

X_____ _____
Counselor Signature Date

Client Name: _____ DOB: _____

TREATMENT **PLANNING IDEAS**

Please complete this page of the form.

It can be hard to think of things to work on in therapy. Some people are aware of so much 'stuff' in their life they have difficulty deciding which bits to work on. Others struggle to find any ideas. This list is to help you identify general areas (like 'interpersonal skills') and specific problem ('finding more useful ways to 'argue'). What we work on is not limited to this list, of course.
Simply circle or put an 'x' next to items you might want to work on and we'll talk about them.

I feel **inadequate**	**Anxiety**	I am a bit **shy** around people
Anger	**Moods** – especially feeling '**down**'	I need a new **type of job**
My **mental health** "stuff"	**Communication**	**Sadness**
How do I **find a job**?	**DWI** arrest/conviction(s)	I have a lot of **STRESS**
I am **too busy**	How do I **grieve** (& not 'lose it')?	A chronic **medical problem**
How do I **not let people bother** me so much?		How do I get **people to change?**
I do **not** need to be here!	How do I **deal** with my **defenses**?	**What** are **defenses**?
Assertiveness training	Ways to **cope** better	How do I **relax**?
My **spiritual** life is 'shot'	Having (sober) **fun**	I have few (or no) **hobbies**
I have little **hope**	I tend to be **impatient**	Life has **no meaning**
People **misunderstand** me	**Relapse prevention** plan	How do I not use **again**?
I want a good **career**	With my **record** how do I get **work**?	Being a **parent** is tough!
Who am I now?	**Money** management	**Who** do I **want** to be?
I have no/few **real friends**	I have important **medical problems**	Handling **feelings**
Fear(s)	**Sleep** problems	I **obsess** about _____
My life is a **mess**!	**Legal** problems	A **traumatic** thing happened
Sexual 'stuff'	It is **too hard to stop using** D/A	I **have good reasons** to use D/A
Been clean, lost it	I really miss _____	I **am not worth** much
I need a **place to live**	I want to get **in shape** (physically)	'**Codependent**' thinking
What have these drugs/alcohol done to my **body**?		What have alcohol/drugs done to my **brain**?

Other: _____