LANTERN LIGHT COUNSELING, PLLC

Holly McFarland, LCSW, JD – Therapist
1624 Enderly Place
Fort Worth, Texas 76104
Phone: 817-888-6657 Fax: 817-887-4649
holly@lanternlightcounseling.com

NEW CLIENT INFORMATION:

Full Legal Name: _____ Today's Date: _____
Home Address: _____ City/State/Zip:_____
Social Security Number: _____ Date of birth: _____
Home Phone: _____ May I leave a message? Yes No
Work Phone: _____ May I leave a message? Yes No
Cell Phone: _____ May I leave a message/text? Yes No
Email Address: _____ May I send appointment reminder? Yes No

Please note – I do not email personal information. Email is only used for scheduling purposes.

How were you referred to me? _____

Person to contact in case of emergency: _____ Relationship to Client: _____
Contact Phone: _____

BILLING INFORMATION:

Billing Full Name: _____ Relationship to Client: _____
Billing Address: _____
City/State/Zip: _____
Billing Phone: _____ May I leave a message? Yes No
Email Address: _____ May I email statement? Yes No

INFORMED CONSENT FOR TREATMENT:

I voluntarily agree to receive mental health assessment, care, and treatment. I authorize Lantern Light Counseling, PLLC/ Holly McFarland to provide such care and treatment as are considered necessary and advisable.
I understand and agree that I will participate in the planning of my care and treatment and that I may stop such care and treatment at any time. I also understand that while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable.
By signing this Informed Consent for Treatment, I acknowledge that I have both read and understood all the terms and information contained herein. I have had ample opportunity to ask questions and seek clarification for anything that is unclear to me.

Client Signature: _____ Date: _____
Parent Signature: _____ Date: _____

CONFIDENTIALITY:

All information between therapist and client is held in strict confidence by the therapist. There are specific and limited exceptions to this confidentiality which include the following:

1) The client authorizes release of information, by signature, as specified in the Release of Information form;
2) Where there is a clear threat to do serious bodily harm to yourself or others;
3) Where there is reason to suspect the occurrence of abuse or neglect of a child, a dependent adult, or a person with developmental disabilities;
4) In response to a subpoena that is associated with a regulatory complaint or in response to a subpoena from a court of competent jurisdiction;
5) Information that must be provided to insurance companies and/or EAP entities as required for the payment of claims, certification/authorization or case management or other purposes related to the benefits of client's health plan.

I have read and understand the Notice of Privacy Practices provided to me by Lantern Light Counseling, PLLC.

Client Signature: _____ Date: _____
Parent Signature: _____ Date: _____

INFORMATION ABOUT YOU:

Please describe your reasons for seeking therapy at this time (include the approximate dates that you noticed pertinent symptoms, any thoughts of hurting yourself or others and any current, major life changes):

_____
_____
_____
_____

Are you currently employed? Yes No
If yes, where do you work? _____
How long have you worked there? _____
Where else have you worked? _____

What is your relationship status (single, married, in a relationship, separated, divorced, widowed)? _____
What is your opinion of your relationship status? _____
Do you have children? Yes No
If yes, please list names and ages: _____
Who do you live with? _____
Are your parents still living? Yes No
Please describe your relationship with them: _____
_____
Please describe any medical and mental health conditions of anyone in your family: _____
_____
_____
_____

Are you currently enrolled in school? Yes No If so, where: _____
Did you complete high school? Yes No
Did you attend college? Yes No If so, did you graduate? _____
Did you attend graduate school? Yes No If so, did you graduate? _____

Do you have any military experience? Yes No Do you have combat experience? Yes No
If yes, what branch? _____
Date of discharge: _____
Type of discharge: _____

MEDICAL HISTORY:

Please list prescription medication you are taking and why (include name, dosage, and frequency):

_____
_____

Please list over-the-counter medication you are taking and why (include name, dosage, and frequency):

_____
_____

Please list any past or present medical conditions for which you have been treated:_____

Most recent examinations	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last vision exam	_____	_____	_____
Last hearing exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgery	_____	_____	_____
Upcoming surgery	_____	_____	_____

How would you describe your overall physical health? _____

MENTAL HEALTH HISTORY:

Have you ever received psychiatric or psychological treatment of any kind? Yes No

If yes, please describe (why, when, where, and how long?):_____
_____
_____
_____

Have you ever received a diagnosis from a mental health provider? Yes No
If yes, what was diagnosis and the date received: _____

What is your opinion of people who seek mental health treatment?: _____

SUBSTANCE USE:

Please check any and all substances that you are currently using:

Caffeine (cups/day) _____ Specify type of caffeine: _____
Cigarettes (packs/day) _____
Alcohol (how much/day) _____
Drugs (how much/day) _____ Specify type of drug: _____

Describe when and where you typically use substances: _____
_____

Describe how your use has affected family and friends (include their perceptions of your use): _____
_____

How do you believe using substances affects your life?: _____
_____

Have you ever attended AA, NA, or Al-Anon? Yes No

Do you have any other information that would be helpful at this time? _____
_____
_____

What do you hope to get out of therapy (what are your personal goals)? _____
_____
_____

Are you suicidal at this time? Yes No
If yes, please explain: _____
_____
_____
_____

FOR STAFF USE:

Therapist's signature: _____ Date: _____

Comments: _____

Please print your name: _____

LIMITS OF CONFIDENTIALITY

Your disclosures here will remain confidential. My utmost concern is to guard your privacy. Nothing discussed here will be disclosed outside the therapy room, except in rare cases as required by law.

By law, it is necessary for me to report any information I have regarding the following:

1) If you are planning on taking your own life;
2) If I determine that you are a danger to someone else;
3) If you disclose abuse, neglect, or exploitation of a child, elderly, or disabled person;
4) If you have knowledge of abuse or neglect taking place in a mental health or rehabilitative facility;
5) If you are a minor – your parents have the right to know about your progress;
6) If your records are subpoenaed in connection with a legal proceeding;
7) If you are in therapy along with someone else (i.e. family therapy), these notes are the property of both parties, and can be obtained by any parties involved;
8) If required by the Secretary of the Department of Health for investigating compliance with the HIPAA Privacy Rule.

THERAPEUTIC RELATIONSHIP

It is imperative that your relationship with your therapist remain solely a therapeutic one. Personal and business relationships would undermine the effectiveness of the therapeutic relationship. While I care about you personally, I am not able to have a personal or business relationship with you. Therefore, gifts, bartering, and trading services are not appropriate.

PAYMENT FOR SERVICES

Initial Visit	$150.00
45-50 minute individual session	$125.00
75 minute individual session	$175.00
25 minute short session	$60.00 (only with therapist agreement)
Court Ordered Therapy session	$150.00
Parent Facilitation session	$200.00/hour (after-hours session $250.00)
Collaborative Law session	$200.00/hour
Phone call greater than 30 minutes	$125.00
Paperwork (forms, copies) greater than 30 minutes	$125.00

In the event that disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records and the therapist's hourly rate of $200.00 for the time involved in preparing for and giving testimony. If I am required to be out of my office for a court appearance or a deposition, there will be a four hour minimum charge plus travel expenses. Such payments are to be made at the time or prior to the time the services are rendered by the therapist.

Forms of Payment: Cash, check, Visa, Mastercard, and Discover are accepted as payment. If your ability to pay for counseling changes, please talk with me. If your account is unpaid and there is no written agreement for a payment plan, I may have to use legal means to obtain payment.

Insurance Reimbursements: Please note that Lantern Light Counseling does not accept insurance as payment. However, upon request, I can provide documentation for out-of-network services. You must then submit this documentation to your insurance company. It is your responsibility to verify the specifics of your coverage.

CANCELLATIONS

If you must cancel an appointment for any reason, please give at least 24 hour notice. Otherwise, you will be billed the regular session fee. You may cancel an appointment 24 hours before your scheduled appointment via telephone or email (817-888-6657 or holly@lanternlightcounseling.com).

If you are late to a session, I will wait 10 minutes, unless you call (817-888-6657) to say you are on your way. Clients arriving late for a session will receive the remainder of the scheduled appointment time and will be responsible for the full fee.

COMMUNICATION WITH LANTERN LIGHT COUNSELING

Holly McFarland's telephone number is 817-888-6657. Email is holly@lanternlightcounseling.com.

If you need to contact me between sessions, please leave a voicemail at the above number. I will return your call as soon as possible. Any calls after 3:00pm will not be returned until the next business day.

THERAPIST'S INCAPACITY OR DEATH

I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allow another licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request, or deliver them to a therapist of my choice. I will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

COMPLAINTS & GRIEVANCES

If you have any problem with me, I encourage you to talk to me directly. I am willing to work with you to resolve identified problems so that you can accomplish your therapeutic goals. If you are unable to resolve problems with me directly, you may contact my licensing board: Texas State Board of Social Work Examiners, PO Box 141369, Austin, Texas 78714-6718.

EMERGENCIES

I do not provide 24 hour crisis counseling

If you have an emergency, **call 911** or go to your nearest emergency room. If you are in crisis, call the MHMR Crisis Line at 817-335-3022. Please do not use my phone number or email for emergencies as I cannot assure I will get your call/email in a timely manner.

EMERGENCY CONTACTS

In the event that Holly McFarland, therapist of Lantern Light Counseling, reasonably believes that I am a danger to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact any person in a position to prevent harm to myself or another person, in addition to suicide assessment services, medical and law enforcement personnel, and the following persons:

Name Relationship Telephone Number

_____

_____

_____

I consent to receive telephone calls at my home, business or cell phone numbers I have provided on this client information form, including texting or having messages left on voicemail. I consent to communication by email for any email address I have provided. I understand that communication via email or on a cell phone is not considered secure and confidential.

I acknowledge and understand that the recording of sessions without the explicit written consent of Holly McFarland is strictly prohibited.

I understand that Holly McFarland and Lantern Light Counseling, PLLC are **not** in a partnership with the office of Susan Wade, LCSW or of Scott Lennox, LCSW.

I have read and understand the above information and agree to the limitations and restrictions set forth herein. I have received a copy of this document and any questions have been answered to my satisfaction. I voluntarily agree to receive mental health care, assessment, treatment, or other services and understand I can terminate such services at any time.

_____ _____

Client Signature Date

_____ _____

Holly McFarland, LCSW, JD Date

CREDIT CARD ON FILE AUTHORIZATION (required)

Payment is due at time of service. Lantern Light Counseling requires that a credit card be kept on file in the event of any unpaid balances, late cancellations, or missed appointments. Cash, checks, and other credit cards may still be utilized at time services are rendered for payment.

Information to be completed by the card holder:

Cardholder Name: _____

Billing Address: _____

Email Address (where statements may be sent, optional): _____

I consent to the use of my credit card for appointments broken without 24 hour notice and for any unpaid fees or services. I understand that my card will be immediately charged the full fee for appointments cancelled and missed without 24 hour notice. I agree to receive billing statements at the email address above that include dates and types of service. I understand that email cannot be guaranteed to be a confidential form of communication. I understand that I may choose not to provide an email address for billing, and any billing statements will instead be sent to the mailing address I have provided above. I attest that I agree to this document, and all the information provided is accurate to the best of my knowledge. I further attest that I am allowed to all the rights and privileges that are associated with this card.

_____ _____

Cardholder Signature Date

Card Number: _____

Card Type: Visa MasterCard Discover

Expiration Date: _____

CVC code: _____