

Please cancel 24 hours before your appointment by calling the office at (409)832-7771 or conveniently cancelling online at [www.pearlsofwisdompow.com](http://www.pearlsofwisdompow.com).

### CLIENT INFORMATION FORM

Please complete each form with the required information. Please scan and return completed forms to email address [admin@pearlsofwisdompow.com](mailto:admin@pearlsofwisdompow.com). Along with the completed forms, please provide a copy of your insurance card. If you prefer not to scan and email back the completed documents and a copy of your insurance card, please bring the completed documents with your insurance card to your scheduled appointment.

DATE: \_\_\_\_\_

*Y.S. Pearl Jessie, M.Ed., LPC*

PERSONAL INFORMATION			
Full Name:	Last Name	First Name	Middle Initial
Street Address			Apartment / Unit #
City		State	Zip Code
Home Phone		Cell Phone	Alternate Phone
Email Address			
Date of Birth (mm/dd/yyyy)		Age	Social Security #
/ /			- -
Marital Status: Married / Divorced / Widowed / Single			
Spouse / Other Name :			

INSURANCE INFORMATION			
Insurance Carrier Name			
Policy #		Group #	Insurance I.D. #
Insured Name (If NOT Self)			
Relationship to Insured			
<input type="checkbox"/> Spouse <input type="checkbox"/> Child/Dependent <input type="checkbox"/> Self <input type="checkbox"/> Other			
Insured DOB (mm/dd/yyyy)		Insured Social Security #	
/ /		- -	

## JOB INFORMATION

Employer Name			
Employer Address: Street Address	City	State	Employer Phone #
Job Title			

## EMERGENCY CONTACT INFORMATION

Name: Last	First		
Home Phone	Cell Phone	Alternate Phone	
Relationship to you?			

## PERSONS SHARING RESIDENCE

Name	Age	Occupation	Relationship

Please answer the following questions to the best of your knowledge.

1. How did you find out about Pearls of Wisdom Counseling Service?

\_\_\_\_\_

2. Who is the MOST supportive to you in your life (church, family, friends, organizations)?

\_\_\_\_\_

3. Have MAJOR changes occurred in your life that have impacted you in a negative manner?

\_\_\_\_\_

\_\_\_\_\_

4. Why you have sought services today? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. When did the problem(s) start? \_\_\_\_\_

\_\_\_\_\_

6. What changes have you noticed within yourself / in your family since the problem began?

\_\_\_\_\_

\_\_\_\_\_

7. Are there any other problems? \_\_\_\_\_

\_\_\_\_\_

8. Have you ever received Mental Health Counseling previously? Circle One: Yes / No

If so, by whom? \_\_\_\_\_ When? \_\_\_\_\_

9. Are you currently taking any meds? Circle One: Yes / No

If so, which meds? \_\_\_\_\_

\_\_\_\_\_

10. Have you been treated for Alcohol/Drug abuse? Circle One: Yes / No

If yes, when? \_\_\_\_\_ Where? \_\_\_\_\_

How many times? \_\_\_\_\_

11. Is this an Employee Assistance Program (EAP) visit? Circle One: Yes / No

If so, which one? \_\_\_\_\_

Confirm/Authorization # \_\_\_\_\_

12. Are you having suicidal thoughts that require immediate attention? Circle One: Yes / No

By signing below you are voluntarily acknowledging that you have received a copy of the disclosure titled "Your Rights and Responsibilities" and that you are giving Pearls of Wisdom Counseling Service, PLLC, the right to use the information that you willingly provided in an administrative capacity. Your information will not be sold or disclosed to third parties not affiliated with Pearls of Wisdom Counseling Service, PLLC as per regulations in connection with HIPPA. By signing below, you are giving the therapist permission to bill your insurance company for services. You are also giving the therapist permission to release information necessary to bill insurance company. Your therapist will only release information that is necessary for billing purposes.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

**Your Rights and Responsibilities**

**All clients of Pearls of Wisdom Counseling Service have the following rights:**

- The right to be treated with dignity as a human being.
- The right to be equally considered as an individual and receive treatment regardless as to your sex, age, race, religion, color, economic status, or sexual preference(s).
- The right to receive professional care and respectful care services.
- The right to your confidentiality. Written consent must be provided by the client before any information is released, with the exception of Pearls of Wisdom Counseling Service being required by law. These areas of law include, but are not limited to imminent issues of suicide, homicide, and/or child abuse, whereas the law requires this information to be released without your consent. These areas also limit your rights to confidentiality. If you have questions in reference to this clause, please feel free to ask Mrs. Y.S. “Pearl” Jessie, LPC.
- The right to know the assessment of the problem, the recommended treatment plan, and any resources available to help improve the problem.
- The right to refuse any treatment by Pearls of Wisdom Counseling Service. Regardless as to how strongly the counselor suggests that you seek help, you have the right to reject the counselor’s advice. In choosing refusal of said advice or treatment you will be advised of the consequences that may adversely follow as a result of your refusal. Please note, alternate forms of treatment or help may be available.

**Your rights also include the following responsibilities:**

- For you to be honest, open and agreeable to communicate your concerns to the counselor.
- For you to feel free to ask questions in reference to clarifying matters or in the event you do not understand a discussed matter.
- For you to communicate any uncertainties or reservations about your treatment plan to the counselor.
- For you to stick to the agreed-upon treatment plan.
- For you to communicate or report any and all changes or unexpected events in reference to your problem to the counselor.
- For you to keep your scheduled appointments. Please contact the office of Pearls of Wisdom Counseling Service or Mrs. Y.S. “Pearl” Jessie, LPC within 24 hours BEFORE your scheduled appointment if you need to reschedule. **EAP CLIENTS:** *Please be advised missed appointments may affect the total number of sessions allowed per year under the EAP.*
- For you to understand you are responsible for your thoughts, feelings, actions, and your growth. Mrs. Y.S. “Pearl” Jessie, LPC is simply here to help gain understanding in reference to those thoughts, feeling, actions, and growth to the best of her ability as a counselor.

**Please sign below as recognition that you have read, that you understand, and accept the information provided in this document.**

\_\_\_\_\_  
**Client’s Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

*Y.S. Pearl Jessie, M.Ed., LPC*

**OFFICE POLICIES**  
**You will receive a copy of this**

In order to prevent misunderstandings about office policies, please read the following:

**CONFIDENTIALITY:** All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law or by court order. The law requires disclosure where there is a reasonable suspicion of child abuse, elder abuse or neglect; where a client presents a danger to self, others, or to property; is gravely disabled; or is significantly impaired from drug and/or alcohol use. In these emergency situations, Y.S. Pearl Jessie, M.Ed., LPC will do whatever she can, within the limits of the law, to prevent clients from injuring self or others and to ensure that clients receive the proper care. Y.S. Pearl Jessie, M.Ed., LPC is legally bound to keep disclosed information confidential.

In judicial proceedings, if a judge orders any records released, Y.S. Pearl Jessie, M.Ed., LPC is legally bound to release said records. In addition, she may be ethically and legally required to take action to protect others from harm even if taking this action means she reveals information revealed by you. An example may be if she is of the belief that a child, elderly person or disabled person is being *abused* and/or *neglected*, she is mandated by law to report this to the appropriate state agency. If she believes a client is threatening **serious** harm to another person or property, she may have to take protective action through notifying the potential victim, police and/or facilitating hospitalization of the client. If she believes a client is a serious threat to harming his/her self, she may have to take protective action (arranging for hospitalization, contacting family/significant others for notification and/or contacting the police.)

Client case files for will be maintained 7 years from the last session date.

**TELEPHONE & EMERGENCY PROCEDURES:** If you need to reach Y.S. Pearl Jessie, M.Ed., LPC between appointments, you may leave a message 24 hours a day, 7 days a week on her confidential, private voice mail at **(409)832-7771**. If your call is urgent and Mrs. Jessie is unable to call you back *immediately*, please call **911**. If you are dealing with a life threatening emergency, please call 911 or go immediately to Fannin Behavioral Hospital at 3250 Fannin St. You may also call the CRISIS Hotline at 1-800-937-0897.

**PAYMENTS:** At each session, payment is expected for any fees due, including insurance co-pays. Appointments may not be cancelled within 24 hours of your scheduled appointed.

**LITIGATION LIMITATION:** Due to the nature of the therapeutic process, which often involves making a full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorneys, nor anyone else acting on your behalf, will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. If this occurs, you will be billed 100.00 for every 1 hour of your therapist's time. A fee of 100.00 must be paid in full (cash or credit card) for the first hour within 24 hours prior to the court date. You will be billed for any remaining amount after the court date and will have to be paid before your next

appointment. Please note, we also charge a fee of 100.00 for records preparation. Court fees are not reimbursable by your insurance company.

**TERMINATION:** If at any point the therapist assesses that she is not effective in helping a client reach the therapeutic goals, Y.S. Pearl Jessie, M.Ed., LPC will discuss it with you. If appropriate, treatment will end and you will be given referrals to other treatment providers more applicable to your needs. You also have the right to terminate services at any time. If you wish to do so, please inform Y.S. Pearl Jessie, M.Ed., LPC directly so the necessary steps may be taken to discharge you from care and close your file.

If you do not show up for a scheduled appointment and Y.S. Pearl Jessie, M.Ed., LPC does not have contact with you for 6 weeks, Mrs. Jessie will assume that you are terminating services, discharge you from care, and close your file.

**Our current fees are as follows:**

- Initial Intake Appointment (60 minutes): **\$75.00**
- Initial Intake / (30 minutes): **\$50.00**
- Subsequent Therapy (50 minutes): **\$75.00**
- Couples Therapy or Family Therapy (50 minutes): **\$75.00**

**Initial \_\_\_\_\_:** If you use your insurance, most insurance agreements require you to authorize us to provide a clinical diagnosis and, sometimes, additional clinical information, such as treatment plans or summaries before they will pay benefits. This disclosure constitutes as written notice and your signature below as your authorization. **You should check with your insurance company directly if you have questions about their confidentiality practices.**

**It is important to remember you always have the right to pay for services privately to avoid the issues described above.**

**Initial \_\_\_\_\_:** For your safety and privacy, please **DO NOT VIDEO, AUDIO, OR DIGITALLY RECORD** your session. Your therapist will not record your session as well. Devices are subject to be lost, stolen, misplaced, etc., and since private matters are discussed in sessions this would not be putting your safety, rights, and privacy first. So when in session please **TURN OFF** all devices, including but not limited to cellular phones, mp3 devices, digital records, tape recorders, and / or video cameras.

**I have read the Office Policies. I understand them and agree to abide by them.** Your signature below indicates that you are making an informed choice to consent to therapy and understand and accept the terms of this agreement.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

*Y.S. Pearl Jessie, M.Ed., LPC*