

Elvin Aydin Keles, PhD, LPC, NCC elvinaydinkeles@gmail.com (832) 669-6905

Client Information Form

Today's Date _____ Home Phone _____ Cell
Phone _____ Work Phone _____

Client's Name _____
Address _____ City _____ State _____ Zip _____ E-
mail _____ Age
_____ Date of Birth _____

Male Female Single Married Divorced Widowed

Where would you like me to leave you messages?

Home Work Cell E-mail None

If there is an emergency at the office and we must cancel your appointment, where should we call? Home Work Cell E-mail None

Employer-Self _____ Occupation _____
Employer-Spouse _____ Occupation _____ Why
are you seeking counseling?

Are you currently in counseling elsewhere? Yes No **If yes, do not complete this form** How were you referred to my office? If internet, please list the directory you used to locate my ad. _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT (PERSON INSURED)?

Name _____ Relationship to Client _____
Address _____ City _____ State _____ Zip _____ E-
mail _____ Age
_____ Date of Birth _____ Soc Sec No. _____ Work Phone
_____ Home Phone _____ Cell Phone _____

ABOUT YOU

Where did you attend public school? _____ Did
you attend college? When, where?

_____ Any
plans to further your education? _____ If so, when and what? _____

ABOUT YOUR HEALTH

Who is your doctor? _____ When was the last visit? _____ Any
concerns shared by the doctor?

Describe any allergies you have _____

_____ Do you
have any chronic medical concerns? _____ Please list _____ Do you have a
Mental Health diagnosis? If so, which one

Are you under the care of a Psychiatrist? If so, whom _____ Have
you been prescribed any psychotropic drugs by your Psychiatrist? Yes No List all
medications or drugs (legal or illegal) you have taken in the last year

_____ Have
List all diseases, illnesses, important accidents and injuries, periods of loss of consciousness,
convulsions/seizures, and any other medical
condition you have had.

Professional Disclosure Statement And Informed Consent

PLEASE INITIAL EACH ITEM:

_____ I understand that Elvin Aydin Keles, PhD, LPC, NCC is a Licensed Professional
Counselor in the state of Texas.

_____ I understand that Elvin Aydin Keles, PhD, LPC, NCC does not provide 24-hour crisis
counseling. Should I experience an emergency necessitating immediate mental health attention,
I will immediately call 9-1-1 or go to an emergency room for assistance.

_____ I understand that during the time that we work together, we will meet weekly for
approximately 50 minutes. While our sessions may be very intimate psychologically, ours is a
professional relationship rather than a social one.

_____ I also understand our contact will be limited to counseling sessions.

_____ I understand that, at any time, I may initiate a discussion of possible positive or
negative effects of entering into the counseling relationship and that specific results are not
guaranteed although benefits are expected from counseling.

_____ I understand that counseling can improve as well as upset the equilibrium in any person
or family. Counseling is a personal exploration and may lead to changes in my life perspectives
and decisions. These changes could be temporarily distressing.

_____ I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship. If at any time I am dissatisfied with Elvin Aydin Keles, PhD, LPC, NCC's services as a therapist, I have a right to let her know. If I do not feel that Elvin Aydin Keles, PhD, LPC, NCC may resolve my complaint, I may file a formal complaint through contact with the Texas Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

_____ I understand that our paths may cross in social situations but that our therapeutic relationship comes first, along with protection of my confidentiality, and that Elvin Aydin Keles, PhD, LPC, NCC does not initiate the greetings.

_____ Should she believe that a referral is needed, Elvin Aydin Keles, PhD, LPC, NCC will provide some alternatives including programs and/or people who may be able to assist me.

_____ I understand that the rate for individual counseling sessions is \$150.00 for a 50- minute session.

_____ I understand that the rate for couples and family counseling is \$250.00 for a 50- minute session.

_____ I understand that all fees for counseling are due after each session.

_____ I understand that conducting expert witness and testimonial services is not an area of

_____ I understand that if I do not cancel my appointment 24 hours ahead of time, the fee for calling or emailing to cancel within 24 hours of my appointment is \$150.00.

_____ I understand that if I do not show up for an appointment it will result in my being charged \$150.00 for full for the full missed session.

_____ I understand that my records and all of our communications become part of the clinical record. Records are the property of Elvin Aydin Keles, PhD, LPC, NCC. Adult client records are disposed of seven (7) years after the client has stopped receiving services

_____ I understand that while most of our communication is confidential there are, however, circumstances when disclosure can occur without my prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

- You are a danger to yourself or someone else.
- In situations of suspected child, spouse, or elder abuse, it is the duty of the mental health provider to notify medical, legal, or other authorities.
- You disclose sexual contact with another mental health professional.
- If you are involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
- Elvin Aydin Keles, PhD, LPC, NCC is ordered by a court to disclose information.
- You direct Elvin Aydin Keles, PhD, LPC, NCC in writing to release your records.
- Elvin Aydin Keles, PhD, LPC, NCC is otherwise required by law to disclose information.

MENTAL STATUS INFORMATION

Have you or your spouse/significant other ever attempted suicide or harmed yourself in any way? Yes No

Are you or your spouse/significant other currently thinking about suicide or harming yourself in any way? Yes No

Have you or your spouse/significant other had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way? Yes No

Are you or your spouse/significant other having any thoughts about harming anyone else in any way? Yes No

STATEMENT OF UNDERSTANDING

I have read the above and understand the nature of service providers and the Limits of Confidentiality outlined above and I solemnly swear that all of the above information is true to the best of my knowledge

Client Signature / Date

AGREEMENT FOR THERAPY

I, _____

- Agree to receive therapeutic services provided by Elvin Aydin Keles, PhD, LPC, NCC.
- I have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both myself and my family.
- Furthermore, I understand that I am expected to be an active participant in this process.
- I acknowledge that I have received and understand the Notice of Privacy Practices for this office.
- My signature below means that I understand and agree with all of the points above.

Client Signature / Date

HEALTH PROVIDER'S STATEMENT

I have inquired to insure that the patient understood the above description of the limits on confidentiality.

Health Provider's Signature / Date

HIPAA 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. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received and understood the HIPAA Notice of Privacy Practices for this office:

Client signature / Date

Consent for Use and Disclosure of Health Information:

I hereby permit and release Elvin Aydin Keles, PhD, LPC, NCC to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

Client signature / Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent