JANET NICHOLAS, MA, LPC, LCDC

DEVIATIONS, INC.

Whitestone Associates
26203 Oak Ridge Drive
The Woodlands TX 77380
(713)882-4268 Appointments

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PATIENT INFORMATION

This will serve as an introduction and address some of the questions you may have about my training and approach.

My name is Janet Nicholas. I am a licensed professional counselor, licensed chemical dependency counselor, EAGALA Certified Equine Assisted Psychotherapist and a Christian counselor. I graduated from Sam Houston State University with a Master's degree in clinical psychology and completed my undergraduate studies at St. Edward's University. Counseling has been my profession for over 20 years.

The majority of my practice consists of working with age 12 through 17 and with adults through the process of psychotherapy. Most often, appointments are scheduled weekly until sufficient progress warrants less frequent sessions. Many clients see me due to a loss or they may be experiencing a crisis. Some people begin psychotherapy because they want to live happier and more productive lives. Others want to address problems in relationships, and some enter therapy to gain assistance in dealing with a symptom or illness such as depression, anxiety, or an addiction. Whatever the reason you are here, research has shown the benefits of psychotherapy. If for some reason I do not feel I can help you, I will tell you. If you wish, I will assist you in finding another therapist. I can also forward your file with your written consent.

My desire is to assist you in reaching your goals. This can often be accomplished through exploration of feelings and by identifying behaviors that limit you and thought patterns that are destructive. Often these can be changed, allowing you to experience greater freedom and inner peace. Through therapy, you may learn how to have healthier and more satisfying relationships, and live life in harmony with your beliefs and values.

If either of us is not satisfied with the progress being made, I may request that you get a consultation with another therapist or physician to ensure that the course of treatment in optimal. It is always important for you to express negative feelings that arise toward me during the time we are working together. Very often, expressing anger or disappointment allows therapy to deepen and greatly enhances the possibility for a good outcome. If you become dissatisfied with my services and we cannot resolve the problem, you may report any complaint to the Texas State Board of Examiners of Licensed Professional Counselors or The Texas Commission on Alcohol and Drug Abuse. At your request I will give you the code of ethics, addresses and telephone numbers.

Confidentiality: All information disclosed within sessions and the written record pertaining to those session are confidential and my not be revealed to anyone without your written permission. The only times that this confidentiality may be broken include when there is reasonable suspicion of child, dependent or elder abuse or neglect and if I believe that you are in danger of hurting yourself or someone else. In some cases a court may order me to disclose certain information. Also, some insurance companies require disclosure of certain information in order to pay for claims.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which 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 attorney's, nor anyone else acting on your behalf will call Janet Nicholas to testify in court or at any proceeding nor will a disclosure of the psychotherapy records be requested.

Payments and Insurance Reimbursement: My fee is $120.00 for an initial evaluation which runs 60 minutes. Thereafter my fee is $105.00 per 50 minute therapy session and $135.00 for family or marriage counseling sessions. If the sessions are shorter or longer the fee may be adjusted accordingly.

If I am an in-network provider for your insurance company, my insurance person will file for you. Insurance must be verified prior to your first visit by calling Michelle at 832-449-3713 or faxing her at 281-569-4624. You will be responsible for your co-pay or deductible. Should your insurance company not pay your claims your balance is your financial responsibility. **If I am not in your network**, you will be provided a receipt that you may file with your insurance company. The fee is due at the time of the session. Please note, if insurance is being used, they require that I diagnose your mental condition and indicate that you have an illness before they will reimburse you for my services. I will discuss with you the diagnosis I plan to render, if you wish, before you file claims with your insurance company. Any diagnosis made will become a part of your permanent health record.

<u>Calls Between Sessions or Emergencies:</u> Should you need to contact me between scheduled sessions, please call 713-882-4268 Monday through Thursday. You may leave a message and I will return your call usually within 24 hours or less. If for some reason I do not return the call, try again. In an emergency you may need to call 911 or go to the nearest hospital emergency department

<u>The Therapy Process</u>: Success in therapy depends to some degree on your desire for change and on your willingness to be honest with yourself and with me. Awareness of need, willingness to feel and to talk about negative emotions, curiosity and openness to direction will assist you in obtaining maximum benefit from our relationship. Although our sessions are conducted in a friendly way and may be quite personal, our relationship will be maintained on a professional basis. My professional code of ethics does not allow me to attend social gatherings with you, accept gifts, goods or services in lieu of payment I consider it an honor that you have chosen me as you psychotherapist. I will endeavor always to warrant your trust and to guard the integrity of our client-therapist relationship.

PLEASE NOTE:

Initial: ____ **<u>Appointments and Cancellations:</u>** Appointments can be scheduled by calling 713-882-4268. Because of the nature of my practice, I am limited in the number of people I can see. **I must request at least a 24-hour advance notice for cancellations in order to use the time for another patient. *<u>With less notice you will be billed for the time set aside for your use.</u>***

I have read and understand the patient information and policies.

____

Client Name (print) Date Signature

____

Therapist Name (print) Date Signature

Janet Nicholas MA, LPC
Patient Information
Please Fill Out Completely

Date: ____________

Patient Name:___________________________________Date of Birth: _______________ Sex: __

Address: ____ SS#: _________________

City: ____State: _______ Zip: _______________

Home Phone: __________________ Work Phone: ______________ Cell: _________________

School or Employer: ____

Employer Address: ________________________ City: _______________State: ____ Zip: ______

Person Responsible for Payment:

Name: ____________________________________ Date of Birth: ____________ Sex: _________

City: ___________________________________ State: ______________ Zip: ____________

City: _______________________________________ State: _____________ Zip: __________

Employer and Address: ____

City: __________________ State: ____ Zip: ______

Home Phone: __________________ Work Phone: ________________ Cell: ________________

I understand and agree that I am responsible for the balance on my account at the time professional services are rendered. The above answers are true and correct. I will notify you if there are any changes in my health status or the above information.

Consent for Treatment

I _________________________________, hereby give my consent to be treated and/or tested by Janet Nicholas, MA, LPC LCDC EAP.

Consent for a Minor Child/Teen

If the patient **is a minor** involved in court proceedings, I will provide proof by the attached court documents that I have legal right to request treatment. The following signatures give consent to be treated or tested by Janet Nicholas LPC LCDC EAP.

Parent Signature: ____ Date: ___________

Parent Signature: ____ Date: ___________

Insurance Verification

Please print and fax ONLY this form to Michelle at 281-569-4624. Please bring the completed Informed Consent and Information Pages to your first appointment.

Date:

Name of Insured	
D.O.B. of Insured	
Social Security Number	
Policy Number	
Group Number	
Address of Insured	
City, State, Zip	
Name of Client	
D.O.B. of Client	

Insurance Company	
Telephone Number	

For Office Use Only

Effective Date			
Annual Deductible	Ind:	Family	Amount Met:
Coverage	%	Limit	Visits per year
Covered	Ind:	Family	Group
Lifetime Maximum			
Pre-Certification			
Re-Certification			

Please fax ONLY this page to 281-569-4624.