W. Travis Stewart, LPC, MATS
Licensed Professional Counselor

1715 Deer Tracks Trail, Suite 260
St. Louis, MO 63131
636-686-0888

To make our first meeting more productive, please give accurate and complete responses to every section of this form. If necessary, write additional information in the margins.

PERSONAL AND FAMILY INFORMATION

_____
Date:

Full Name: Date of Birth: Age:

Address City State Zip

May I send mail (e.g., a bill or other necessary information) to this address? ☐ Yes ☐ No

Primary phone number Secondary phone number

_____
Email address May I send information to this email? ☐ Yes ☐ No

EDUCATION: Circle last year of school completed: 9 10 11 12 GED College: 1 2 3 4

Indicate any graduate education:

CAREER:
Indicate career/education status (circle all that apply)
Student Part-time employment Full-time employment

Marital Status: ☐ Single, never married ☐ Engaged ☐ Other
☐ Separated ☐ Divorced ☐ Married

If married, or living together, name of spouse or partner: _____ Age

Any other information regarding marriage or relational status:

CHILDREN:

Name	Age	Sex	Living with you?
		M/F	Yes/No
		M/F	Yes/No
		M/F	Yes/No
		M/F	Yes/No

COUNSELING HISTORY

Have you previously sought counseling? ☐ Yes ☐ No

Name of provider Dates seen

Name of provider Dates seen

How satisfactory was your experience(s)?

Are you presently working with any other Counselor or Psychologist? ☐ Yes ☐ No

For what reason?

Counselor name:

Are you involved in any other counseling or support group? ☐ Yes ☐ No

Specify

MEDICAL INFORMATION

Family Physician Psychiatrist

Are you taking any prescription drugs? ☐ Yes ☐ No

If Yes, state the drug name (s), type and for what purpose?

Describe your physical health? ☐ Very good ☐ Good ☐ Adequate ☐ Poor ☐ Declining

Current medical problems and/or medications.

_____

_____

Please list any sleep disturbances.

_____

_____

Have you ever been hospitalized for mental illness or substance abuse? ☐ Yes ☐ No

_____

If yes, for what reason?

_____

How long in treatment?

_____

Facility name Dates

Did you continue with Outpatient counseling? ☐ Yes ☐ No

CONSENT FOR TREATMENT

I _____ give permission to W. Travis Stewart, Licensed Professional Counselor, to provide counseling to me and/or the minor under my care.

As a client of my office it is your right to have the content of your therapy sessions held in confidence with these exceptions in which I am mandated by law to report:

1) if you sign a release form for me to divulge any or all information,
2) if you intend suicide, or if you intend to do serious physical harm to yourself,
3) if you intend homicide,
4) if a child, elderly person, or disabled person is being abused or has been abused, or
5) in the case of exploitation by a mental health professional.

In some cases, the Missouri courts have held that if an individual intends to take harmful or dangerous action against another individual, it is the counselor's duty to warn the person and/or the family of the person who is likely to suffer the results of harmful behavior.

Every effort will be made to resolve these issues before such a violation of confidentially takes place. Every effort will be made to prevent an attempted suicide or a dangerous action against another person.

Professional consultation:
In following ethical and professional standards, occasionally therapists consult with other professionals to gain other perspectives and ideas on how to best serve you. Unless you have signed a release, no identifying information is shared during these consultations.

By signing below, I affirm that the information given on this form is true and complete.

I have read and agree to the above policies, procedures and statements.

Signature of Client	Printed Name of Client	Date
Signature of Client	Printed Name of Client	Date
Signature of Parent/Guardian (if client is minor)		Date
Printed Name of Parent/Guardian		
Signature of Counselor	Date	

W. Travis Stewart, LPC, MATS
Licensed Professional Counselor

1715 Deer Tracks Trail, Suite 260
St. Louis, MO 63131
636-686-0888

MY APPROACH TO COUNSELING

I welcome you as a new client, and look forward to working with you! The purpose of this form is to let you know about my approach to counseling and what you can expect from counseling,

It is my desire to provide a written record of the agreement that we have reached to provide counseling services to you. I have found from experience that such a written record serves both the client and the counselor in good stead should questions later arise with respect to any of the services that we have agreed to perform. This statement should serve as a point of reference should any questions arise.

I view the counseling process as forming an alliance with you, to explore the nature of your problem. Although we will spend much of our time exploring the specific problem that brought you into counseling, we will also explore, in depth, the nature of your relationship with other significant people in your life. In my theoretical orientation, I believe that many of the forces and dynamics that have influenced the complexity and intensity of your problem are rooted in relational issues. This is not to simplify your problem, but rather to highlight the complexity of the problem and how it interferes with the deep enjoyment for which you have been made.

In working toward the goals of removing the initial problem and growing in relational maturity, the counseling process will require that firm effort is made to change, which may involve significant discomfort. Remembering and resolving unpleasant events can arouse intense fear, anger, depression, frustration, and other powerful emotions that may feel foreign, but are a normal part of the process of growth. Seeking to resolve issues between family members, marital partners and other persons can similarly lead to discomfort, as well as relationship changes that may not have been originally intended.

I believe that certain problems can also have (or develop) physical components. In such cases, medical consultation will be advised.

The course of therapy is determined mutually by your counselor and you, the client. You are encouraged to freely ask any questions you have regarding my educational and professional background or therapeutic approach. You are also encouraged to freely ask questions pertaining to your specific therapy plan and progress. **People often ask how long they will be in counseling.** I attempt to work with people in such a way that they have sufficient time to meet their individual therapy goals, but we discourage clients from becoming inappropriately dependent upon therapy. Consequently, treatment duration varies from person to person. State certification requirements for professional counselors

do not imply the effectiveness of treatment. It is your responsibility to determine whether the services offered are appropriate and ultimately helpful.

It is always my intention to provide services in a professional manner that is consistent with all accepted ethical standards. If at any time in the course of your work with me you feel that there may have been a misunderstanding or you have a question or complaint about my services, please bring this up immediately so that I can become aware of your concern and resolve the matter with you.

I hope that you find this counseling experience to be successful, and in some way enjoyable.

W. Travis Stewart, LPC, MATS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED ANDHOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and as applicable law permits the terms of this Notice at any time, reflecting such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In event of you incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or a law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, within limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $25.00 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare as summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you requested this accounting more than once in a 12- month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of you health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e- mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this Notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. You may complain to us using the contact information listed at the end of this Notice.

We support your right to the privacy of your health information.

Contact: Telephone: Address:

W. Travis Stewart, LPC, MATS
636-686-0888
1715 Deer Tracks Trail, Suite 260 St. Louis, MO 63131

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ , have received a copy of this office's Notice of Privacy Practices from W. Travis Stewart, LPC, MATS.

_____

Signature Date

_____

Printed Name

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)