



# Shirley Jean Schmidt, MA, LPC

sjs@shirleyjeanschmidt.com / www.shirleyjeanschmidt.com  
Phone: 210-561-9200 / Cell: 210-863-3694 / Fax: 210-561-7806

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**Welcome to my psychotherapy practice!** The following is provided to help you become acquainted with the way I work. Please take time to read it carefully. I will gladly discuss any of these items with you.

- ✘ Effective psychotherapy requires a good match between client and therapist. During our first session or two we will determine if I'm a good choice of therapist for you. If not, I will refer you to a therapist I believe can serve you better than I.
- ✘ Because I divide my time between private practice and teaching workshops out of town, I'm not always available for crisis management. Clients who have frequent crises, or who need a lot of between-session therapist support, will be referred to therapists who are more available for that level of care.
- ✘ I assume you wish to begin therapy because you desire certain changes in your life. I will do my best to help you achieve your goals, but I cannot guarantee any particular result. You are likely to gain the most benefit from counseling if you are committed to the process and attend regularly.
- ✘ I developed a psychotherapy model called the Developmental Needs Meeting Strategy (DNMS). The DNMS is focused on healing childhood wounds associated with trauma and unmet needs. I use this approach with most clients I treat. There is a slide show on my web site, which will introduce you to this model. You are encouraged to watch it and share your thoughts about it with me when we meet.
- ✘ Since biological factors can contribute to unwanted psychological distress, I may ask you about your health and diet. In some cases medical assessment and intervention is helpful and/or necessary. Some individuals benefit from a combination of psychotherapy and drug therapy.
- ✘ From time to time I may ask you to fill out various questionnaires. Please fill these out as best you can, it helps me learn important details about you without taking up extra session time.

## Session Fees

- ✘ My fee is \$100 per hour. If this fee is out of range, we can discuss other payment options. I take VISA and MasterCard for those who need a payment plan. If you cannot afford my minimum fee contact the United Way Help Line, at 227-HELP, for information about low fee counseling clinics for children, adolescents, adults, and/or families.
- ✘ Payment for therapy will be due at the end of each session. If you need to defer payment, or require a payment plan, you may use VISA or MasterCard.
- ✘ I do not have a secretary to collect your fees, so please come prepared to pay with cash, check, or credit card at the end of our session.
- ✘ ***If you plan to submit your session receipts for insurance reimbursement, please inform me right away.*** Attached to this file is a list of questions to ask your insurance company, to determine whether or not they will reimburse your claims, and if so, under what conditions. If they agree to reimburse you for the counseling, the session receipt you submit must contain ***a diagnosis and my signature***. You will be responsible for payment at the end of each session whether your insurance company reimburses you later or not.

## Additional Fees

- ✘ **Short-Notice Cancellation Fee:** Appointment cancellations made within 24 hours of the scheduled appointment will be subject to a fee of half (½) of the total session charge. This charge may be waived if we can move your appointment to another time in the same week.
- ✘ **No-Show Fee:** If you do not show up for a scheduled appointment (that you hadn't canceled) you will be charged the full fee for the session. If you are inclined to forget appointments please let me know – I will arrange to call you in advance to confirm your appointments.
- ✘ Phone consultations lasting more than 15 minutes will be charged at the hourly rate.
- ✘ If your insurance company should ask for a letter or report to be mailed on your behalf you will be billed for the time required to prepare the document, at the hourly rate.
- ✘ If a check of yours is returned by the bank for insufficient funds, you will be responsible for reimbursing any bank fees charged to my account for your returned check.

## Scheduling

- ✘ I will make every effort to schedule your appointments at times that are convenient for you.
- ✘ Clients typically schedule 50-minute, 80-minute, or 105-minute sessions – one per week, or one every other week. The length and frequency of your sessions will be your decision. Longer sessions that are scheduled close together tend to result in the most efficient outcome.
- ✘ If you need to cancel or reschedule an appointment please give as much notice as possible. Do not leave appointment-change messages on my office phone. If you need to cancel or change your appointment, please call my cell phone, 863-3694, or e-mail me at sjs@shirleyjeanschmidt.com.
- ✘ Clients arriving late will be responsible for paying for all the session time scheduled.
- ✘ I do not have a secretary to schedule my appointments. If possible, please come prepared to schedule your next appointment at the end of each session.

## Confidentiality

Except for certain situations, matters shared in counseling sessions will not be disclosed to anyone without your written permission. There are some exceptions to this:

- ✘ Therapists are legally required to report suspected abuse, neglect, or exploitation of a child, an elderly person, or a disabled person to the appropriate agency.
- ✘ Therapists have a legal and ethical obligation to warn appropriate authorities, family members, etc., when a client is seriously considering harming him/herself or others.
- ✘ Client case notes and records may be subject to subpoena when a client is involved in civil or criminal legal proceedings.
- ✘ Therapists may be required to release client information to an insurance company that is paying for the treatment. Many insurance companies will require documentation of a client's therapy progress before pre-approving additional sessions.

## Phone Calls, E-mails, Emergencies, and Between Session Support

- ✘ If you need to cancel or reschedule a session, or if you need to reach me right away, call my cell phone at **863-3694**. If I don't answer, leave a message and I'll call you back at my earliest convenience.
- ✘ If you are having an urgent crisis and need immediate assistance, please call the **24-hour Crisis Hotline at 227-4357 (227-HELP)**.
- ✘ When deciding whether or not to call me between sessions, please consider the following guidelines:
  - The crisis, question, or dilemma cannot wait until the next session.
  - Someone is in danger of harm, injury or death.
  - The crisis cannot be eased by supportive friends or family members.
  - The use of a stress reduction technique has not sufficiently eased the sense of emergency.
- ✘ I divide my time between private practice and teaching workshops out of town. Clients who have frequent crises, or who need a lot of between-session therapist support, will be referred to therapists who are more available for that level of care.
- ✘ **E-mail guidelines:** You may e-mail me to make, cancel, or reschedule an appointment, to make brief reports about your progress, or to ask simple questions that can be answered in a few words. But deep therapy issues, questions, or crises will not be addressed by e-mail.

## Consent for Therapy

I, \_\_\_\_\_, give permission to Shirley Jean Schmidt, MA, LPC (License #13655), to provide psychotherapeutic treatment. I understand that services will be rendered in a professional manner, consistent with accepted ethical standards. By my signature I am affirming that the contents of this document have been satisfactorily explained to me.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If psychotherapy services are not rendered in a professional and ethical manner, you may file a complaint with the Texas State Board of Examiners of Professional Counselors.



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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Sex: *Male Female* Ethnicity: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Marital status (circle all that apply): *Single Engaged Living together Married Separated Divorced Widowed*

Name of Spouse: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

E-mail: \_\_\_\_\_ Referred by: \_\_\_\_\_

<u>Names of Children:</u>	<u>Age</u>	<u>Gender</u>	<u>Living w/ you?</u>		<u>Comments:</u>
_____	_____	<i>M F</i>	<i>Yes</i>	<i>No</i>	_____
_____	_____	<i>M F</i>	<i>Yes</i>	<i>No</i>	_____
_____	_____	<i>M F</i>	<i>Yes</i>	<i>No</i>	_____
_____	_____	<i>M F</i>	<i>Yes</i>	<i>No</i>	_____
_____	_____	<i>M F</i>	<i>Yes</i>	<i>No</i>	_____

Briefly state your reason for seeking counseling at this time:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever been seen by a mental health professional before? *Yes No*  
If yes, please indicate who, when and why:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Would you consent for Shirley Jean Schmidt to contact him/her on your behalf? *Yes No*

Do you regularly practice relaxation techniques (e.g. meditation, yoga, Tai Chi)? Yes No

If yes, what and how often? \_\_\_\_\_

How often do you get therapeutic massage? \_\_\_\_\_

How often do you get 20 minutes or more of exercise? \_\_\_\_\_

How many caffienated drinks (coffee, sodas, tea, hot chocolate) do you usually drink per day? \_\_\_\_\_

How many food and drink products containing Nutrasweet do you usually consume each day? \_\_\_\_\_

How much do you usually smoke? \_\_\_\_\_

How much alcohol do you usually drink? \_\_\_\_\_

Do you use "recreational" drugs? Yes No If yes, what and how often? \_\_\_\_\_

\_\_\_\_\_

Do you take vitamins and/or herbal remedies? Yes No If yes, what and how often? \_\_\_\_\_

\_\_\_\_\_

Which category best describes your diet?

- Very Healthy* (Lots of fresh fruits/vegetables/whole grains, and few sweets/fatty foods.)
- Between Moderately Healthy & Very Healthy*
- Moderately Healthy* (Some fresh fruits/vegetables/whole grains, and some sweets/fatty foods.)
- Between Unhealthy & Moderately Healthy*
- Unhealthy* (Few fresh fruits/vegetables/whole grains, and lots of sweets/fatty foods.)

Who is your primary physician?

Phone #:

Please list any troublesome or significant medical conditions you may have.

Please list your current medications (Prescription & Non-Prescription):

<u>Drug</u>	<u>Dose</u>	<u>Frequency</u>	<u>When Started</u>	<u>For what symptom(s)</u>	<u>Prescribing Doctor</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Who should be notified in case of emergency?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Pager: \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

## Symptom Frequency Scales

How often have you experienced the following symptoms over the last two weeks?

<b>Depression</b>	<i>Not at all</i>	<i>Sometimes</i>	<i>All the time</i>	<input type="checkbox"/> Drug Related
Feelings of sadness	0 1 2 3 4 5 6 7 8 9 10			
Difficulty falling asleep and/or staying asleep	0 1 2 3 4 5 6 7 8 9 10			
Desire to spend a lot of time sleeping	0 1 2 3 4 5 6 7 8 9 10			
Fatigue or loss of energy	0 1 2 3 4 5 6 7 8 9 10			
No interest in formerly pleasant activities	0 1 2 3 4 5 6 7 8 9 10			
Feelings of worthlessness	0 1 2 3 4 5 6 7 8 9 10			
Feelings of hopelessness	0 1 2 3 4 5 6 7 8 9 10			
Feelings of excessive and/or inappropriate guilt	0 1 2 3 4 5 6 7 8 9 10			
Thoughts of being punished	0 1 2 3 4 5 6 7 8 9 10			
Impaired ability to concentrate	0 1 2 3 4 5 6 7 8 9 10			
Indecisiveness	0 1 2 3 4 5 6 7 8 9 10			
Excessive appetite OR poor appetite	0 1 2 3 4 5 6 7 8 9 10			
Feelings of restlessness	0 1 2 3 4 5 6 7 8 9 10			
Sense of moving slowly	0 1 2 3 4 5 6 7 8 9 10			
Thoughts of death	0 1 2 3 4 5 6 7 8 9 10			
Thoughts of suicide	0 1 2 3 4 5 6 7 8 9 10			
Unplanned weight gain OR weight loss	NO YES If yes, how much?			

<b>Anxiety</b>	<i>Not at all</i>	<i>Sometimes</i>	<i>All the time</i>	<input type="checkbox"/> Drug Related
Inability to relax	0 1 2 3 4 5 6 7 8 9 10			
Nervousness	0 1 2 3 4 5 6 7 8 9 10			
Numbness or tingling	0 1 2 3 4 5 6 7 8 9 10			
Heart pounding or racing	0 1 2 3 4 5 6 7 8 9 10			
Indigestion and/or discomfort in abdomen	0 1 2 3 4 5 6 7 8 9 10			
Feelings of choking	0 1 2 3 4 5 6 7 8 9 10			
Shaky	0 1 2 3 4 5 6 7 8 9 10			
Scared	0 1 2 3 4 5 6 7 8 9 10			
Difficulty breathing	0 1 2 3 4 5 6 7 8 9 10			
Racing thoughts	0 1 2 3 4 5 6 7 8 9 10			
Sweating (not due to heat)	0 1 2 3 4 5 6 7 8 9 10			
Dizziness or lightheaded	0 1 2 3 4 5 6 7 8 9 10			
Fear of the worst happening	0 1 2 3 4 5 6 7 8 9 10			
Fear of losing control	0 1 2 3 4 5 6 7 8 9 10			
Fear of dying	0 1 2 3 4 5 6 7 8 9 10			



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## Questions to ask your insurance company. . .

- Does my policy include a **mental health benefit**? Yes No

**If yes:**

- Does my policy cover **Licensed Professional Counselors (LPCs)**? Yes No

**If yes:**

- Does my policy cover **out-of-network** LPCs? Yes No

**If yes:**

- How much will my policy pay for a 50-minute psychotherapy session? \_\_\_\_\_
- How much will my policy pay for an 80-minute psychotherapy session? \_\_\_\_\_
- How much will my policy pay for a 105-minute psychotherapy session? \_\_\_\_\_
- How much psychotherapy is covered per year? \_\_\_\_\_
- Is my **mental health deductible** part of, or separate from, my medical deductible? \_\_\_\_\_
- What is my yearly mental health and/or medical deductible? \$ \_\_\_\_\_
- How much of my deductible have I met this year? \$ \_\_\_\_\_
- Can I pay my therapist out-of-pocket and submit my session receipts for reimbursement? Yes No

**If yes:**

- To whom should I mail or fax the receipts? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Once I mail in a receipt, how long before I receive a reimbursement check? \_\_\_\_\_
- Do you require **pre-approval or pre-certification** of sessions? Yes No

**If yes:**

- Who must obtain the pre-approval or pre-certification? *Myself My therapist Either*
- Can this be done over the phone? Yes No  
If not, what is the procedure? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- How many sessions will likely be pre-approved at a time? \_\_\_\_\_
- Who should be contacted to authorize the pre-approval? \_\_\_\_\_  
\_\_\_\_\_
- Is there anything else I should know? \_\_\_\_\_