



Myron D. Jones, PH.D, LPC-S, LCDC
9441 LBJ Freeway Suite 515, Dallas, TX 75243

PROFESSIONAL DISCLOSURE STATEMENT

Qualifications: Myron Jones is a Licensed Professional Counselor, and a Licensed Chemical Dependency Counselor. His areas of expertise include marriage and family therapy, grief and loss, as well as working with adults and adolescents. In addition to individual and couples therapy, he offers a variety of groups including female self-esteem, divorce, anger management, etc...

Experience: Myron completed his undergraduate and graduate degrees at Texas A&M University - Commerce and received his Ph.D from Texas A&M University - Commerce. While in graduate school, he completed his internship at the Counseling Institute of Texas where we worked with children, adolescents, couples and families. He later completed his second internship at Nexus Recovery Center where he worked with adult women dealing with substance abuse issues. In addition, Myron continued working with families and individuals at both Harold Murphy Counseling Center and All Nations Fellowship Church.

Nature of Counseling: It is my theoretical belief that an individual has the potential to grow and the capability to change. I believe establishing a relationship based on trust and understanding is imperative for healing to take place. I feel it can be beneficial to explore and individual's past relationships and experiences to see if they are currently influential. Our relationship will be a collaborative one where we will both work together to accomplish your goal for the counseling process.

INFORMED CONSENT

Emergency/Crisis: Please know that New Outlook Counseling and Wellness Center, LLC does not provide a 24-hour crisis counseling service. Should you experience an emergency necessitating immediate mental health attention call 9-1-1 or go to the nearest emergency room for assistance.

Counseling Relationship: During the course of counseling, you and/or your child will meet with Myron for approximately 50 minute sessions. Although sessions may be psychologically intimate the relationship between client and therapist is professional. Please do not ask me to relate to you in any way other than the professional context of counseling sessions.

Effects of Counseling: At any time you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a process of personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.



Clients Rights: Some clients need only a few counseling sessions to achieve their goals; others may require months or even years. As a client, you are in a complete control and may end our counseling relationship at any time, though I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any counseling techniques or suggestions that you believe might be harmful.

You are assured that counseling services will be rendered in a professional manner consistent with accepted legal and ethical standards as stipulated by the Texas State Board of Examiners of Licensed Professional Counselors and the HIPAA security and privacy rules. If at any time, for any reason you are dissatisfied with the services at New Outlook Counseling please let me know so that existing issues can be worked through. If I'm not available to resolve your concerns you may report your complaint.

Referrals: Should you and/or I believe that a referral is needed; you will be provided with some alternatives, including program and/or people who may be available to assist you. Also, should you miss two appointments concurrently for whatever reason; a referral will also be provided. You will be responsible for contacting and evaluating those referrals and/or alternatives.

Fees: In return for a fee of \$160.00 per session New Outlook Counseling agrees to provide counseling services for you. The original intake session is \$200.00. The fee for each session is due at the beginning of each session. Couples Therapy is billed at \$200 per session. The intake session is \$250.00. Sundays are cash pay only. Individual sessions will be billed at \$200 per session and couples therapy will be billed at \$250.00 per session.

The rate for all related counseling services, including but not limited to, time incurred due to phone calls over 5 minutes, medical concerns, psychiatric concerns, home and family social studies, child protective service cases, adoption and foster care, issues of divorce, child custody, attorney consultations, educational concerns, behavioral concerns, ARD meetings, classroom observations, interactions with insurance providers etc... will be billed at \$120.00 per hour in 15 minute increments. In the case of off-site services, fee includes travel time to and from New Outlook Counseling. Checks are payable to "New Outlook Counseling."

CANCELLATION POLICY: In the event you are unable to keep an appointment, please give notification of 24 hours or more. **IF A CANCELLATION OCCURS WITHOUT A 24 HOUR NOTICE OR YOU FAIL TO KEEP YOUR SCHEDULED APPOINTMENT, A REGULAR SESSION FEE WILL BE BILLED TO YOU.** All returned checks will incur a \$25.00 return-check fee. If you are absent two weeks in a row without contacting me you will be provided with other referral sources for further counseling. Likewise, if you are absent three sessions in a row, even with contact, you will be provided with other referral sources for a continuation of counseling at a different facility. If you do, at any time, intend to discontinue counseling please inform me as soon as possible so that other clients can be serviced.

Records and Confidentiality: All of our communications become part of the clinical record. Records are the property of New Outlook Counseling. Adult client records are disposed of six years after the file is closed. Minor client records are disposed of six years after the clients 18th birthday. Most of our communication is confidential, but the following limitations and exceptions do exist: a) you are a danger to yourself or someone else; b) you disclose sexual contact with another mental health professional; c) I am ordered by a court to disclose information; d) you direct me to release your records; e) there is a reason to believe that abuse or neglect of a child, elderly, or disabled person occurred or a situation exists possibly leading to abuse or neglect; or f) I am otherwise required by law to disclose information.



Should you or an entity through your signature request a copy of you or your child’s counseling records please be aware that a \$30.00 record preparation fee will be incurred and a “Release of Records” form must be signed. An overall counseling summary in lieu of records may also be provided. A fee of \$30.00 per 15 minutes is charged for preparation time. If records are subpoenaed this does not indicate an automatic release of records and is at liberty to be squashed should it be deemed not in the client’s best interest. To further protect your confidentiality if I see you in public I will only acknowledge you if you approach me first.

Court: It is in your best interest to know that conducting expert witness/testimonial service is not in my area of interest or expertise. I do not agree to serve as an expert witness or to provide testimonial services for you, and you agree not to cause my services to be used in this way. If you are seeking counseling for court or court related purposes or motivations I will provide you alternative appropriate sources. Should you, your attorney, your spouse or ex-spouses attorney subpoena me or your client files as a factual case witness or involve me in court related proceedings, you agree to pay \$300.00 for every hour of my time involved, including case preparation, travel, witness time, and any wait time related to a court related process. You further agree to pay a retainer fee of \$2,400.00 at the time a subpoena is served to be applied toward these charges. If a subpoena is issued for me it will be turned over to an attorney, and I will consult with an attorney as necessary at your expense. A bill will be rendered to you for immediate payment when a subpoena is issued. If you have a suspicion that your case will be going to court, or you will need therapist testimony, please let me know before a counseling relationship is established, and appropriate referral sources will be provided to you.

Please note* 24 hour advance notice is required if a cancellation occurs related to a court process, including dismissal of case. If a 24 hour notification is not made, a fee of \$2,400.00 will be billed. (8hrs @ \$300.00 per hour)

By my signature below, I acknowledge reading and understanding this document, and that any questions I had about this document were answered to my satisfaction, and that I was furnished a copy of this document. My signature below acknowledges my commitment to comply with all its terms and requirements, issue consent for Myron D. Jones, PH.D, LPC-S, LCDC, to work with me, understand and agree to my financial obligations including the cancellation policy stated above, and acknowledge my commitment to conform to its entire specifications.

Client/Guardian Signature

Date

Counselor Signature

Date

Updated Jan 2015

Client Copy



Myron D. Jones, PH.D, LPC-S, LCDC
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Client/Guardian Signature

Date

Counselor Signature

Date

Updated Jan 2022

Counselor Copy



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CONFIDENTIALITY & CONSENT FOR SERVICES

This agency holds your confidentiality in the highest regard from your identity to the information you offer in session. All client information is protected under both state and federal confidentiality laws. Specific information pertaining to your case will not be released to anyone except for specific billing purposes, your request for a release, situations involving risk to harm (see below), or court orders relating to a criminal case or investigation. There are certain limitations to confidentiality, some of which are required by law and others are required by the professional ethical code. Please be aware of the following exceptions to privileged communications:

- 1. Any evidence or reason to believe that a situation of child, elderly or handicap abuse and/or neglect exists. By law, this information must be reported to the Texas Department of Protective and Regulatory Services.**
- 2. Any probability of physical harm to yourself or others. Protection from physical injury takes precedence over confidentiality and the therapist’s primary responsibility is his/her “duty to warn” if she/he believes someone to be in imminent physical danger. Therefore, if an individual intends to take harmful, dangerous, or criminal action against self or another, it is the therapist’s duty to report such action or intent to the authorities.**
- 3. If subpoenaed by a court, this may involve providing the court with verbal testimony and/or records such as clinical notes, tapes, letters, testing, and ledgers.**
- 4. If a third-party billable service is paying or reimbursing for counseling services it may be necessary to provide the billable party with counseling diagnoses, nature, and progress.**
- 5. If client discloses that they have a disease commonly known to be both communicable and life threatening counselors may be justified in disclosing information to identifiable third parties if they are known to be at demonstrable and high risk of contracting the disease.**

I (we) do hereby give my (our) consent for counseling and/or related services at this facility. I (we) understand that all information pertaining to my (our) services all remain completely confidential except in those cases where confidentiality is limited. These limits of confidentiality, as prescribed by Texas law, have been explained to me. I (we) further understand that any release of information concerning my (our) services shall occur only with my (our) written consent, excluding that above stipulated exceptions.

Client/Guardian Signature

Date

Counselor Signature

Date



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Court Testimony Agreement

- I am seeking counseling for court testimony or court involvement on behalf of Myron D. Jones, PH.D, LPC-S, LCDC for myself, my child, or a family member.
- I am NOT seeking counseling for court testimony or court involvement on behalf of Myron D. Jones, PH.D, LPC-S, LCDC for myself, my child, or a family member.

Court: It is in your best interest to know that conducting expert witness/testimonial service is not in my area of interest or expertise. I do not agree to serve as an expert witness or to provide testimonial services for you, your child or any member of your family, and you agree not to cause my services to be used in this way. If you are seeking counseling for court of court-related purposes or motivations, I will provide you with alternative appropriate referral sources. Should you, your attorney, your spouse or ex-spouses attorney subpoena me or your client file as a factual case witness, or involve me in court-related proceedings, you agree to pay \$300.00 for every hour of my time involved, including case preparation, travel, witness time, and any wait time related to a court related process. You further agree to pay a retainer fee of \$2,400.00 at the time a subpoena is served to be applied toward these charges. If a subpoena is issued for me it will be turned over to an attorney, and I will consult with an attorney as necessary at your expense. A bill will be rendered to you for immediate payment when a subpoena is issued. If you have a suspicion that your case will be going to court, or you will need therapist testimony, please let me know before a counseling relationship is established, and appropriate referral sources will be provided to you.

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By your signature below, you are indicating that you read and understood this document, that you are in full agreement with the contents of this document, and that any questions you had about this document were answered to your satisfaction.

Client/Guardian Signature

Date

Counselor Signature

Date



CONSENT FOR DISCLOSURE OF INFORMATION

I, _____ hereby provide authorization for Myron D. Jones, PH.D, LPC-S, LCDC

To obtain and/or provide the following information:

To/From the following parties/agencies:

Agency Name

Contact Name

Address

City, State, Zip Code

New Outlook Counseling

Myron D. Jones, PH.D, LPC-S, LCDC

9441 LBJ Freeway, Suite 515

Dallas, TX 75243

Fax Number: 214-504-1337

Client/Guardian Signature

Date

Counselor Signature

Date



Myron D. Jones, PH.D, LPC-S, LCDC
9441 LBJ Freeway Suite 515, Dallas, TX 75243

HIPPA 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 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 condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health insurance may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist’s practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose as needed, your protected health information to support the business activities of your therapists practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing, and fund raising activities, conducting or arranging for other business activities. For example, we may disclose your protected health information to graduate students and Licensed Professional Counselor Interns who see clients at our office. In addition, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

Other permitted and required uses and disclosures will be made only with your consent, authorization and opportunity to object, unless required by law. You may revoke this authorization in writing at any time, except to the extent that your therapist or therapists practice has taken an action in reliance on the use or disclosure indicated in the authorization.



Acknowledgment of Receipt of HIPPA Notice of Privacy Practices for this office:

Client Signature (parent/guardian of minor patient)

Date

Consent for use and disclosure of health information:

I hereby permit and release Myron D. Jones, PH.D, LPC-S, LCDC 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 HMO's, PPO's, managed care organizations, IPA's or other governmental or third party payers, or any organization contracting with any of the above entities to perform such functions.

Client Signature (parent/guardian of minor patient)

Date

You have the right to request restriction of uses on disclosure 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.



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General Intake Information

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: M F

Home Address: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____
City St Zip

Contact you at work? Yes No Contact you at home? Yes No Contact you on cell? Yes No

Email Address: _____

May I correspond with you via email at the address specified above? Yes No

Occupation: _____ Length of time at this job: _____

Work days & hours: _____ Would you consider this job stressful? Yes No

Referred by: _____

Activities and/or hobbies you enjoy: _____

History of learning, emotional, or behavioral problems? Yes No

(if yes explain) _____

History of alcohol, drug/substance abuse? Yes No

(if yes explain) _____

History of criminal activity? Yes No

(if yes explain) _____

Emergency Contact Name: _____

Relationship to you: _____ Phone Number: _____

*Your signature on page 5 indicates consent to
contact this person in the rare case an emergency should occur.*



General Health: Excellent Good Fair Poor Date of last physical: _____

Primary Care Physician: _____ Phone Number: _____

Address: _____
City St Zip

Current Diagnosis or Medical Concerns: _____

Psychiatrist: _____ Phone Number: _____

Address: _____
City St Zip

Current Diagnosis or Medical Concerns: _____

List all current medications you are taking:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Have you ever seen a mental health professional? Yes No *Counselor, Psychologist,*

Psychiatrist *Are you **currently** in counseling elsewhere? Yes No

If yes we require written confirmation of the counselor's consent for treatment at New Outlook Counseling.

Past Counseling History:

Date Date of Service Agency and Therapist Services

Have you ever been hospitalized for mental health concerns? Yes No Date: _____

Briefly describe why you are seeking counseling?



Please give three adjectives to describe your relationship with your mother as a young child:

Please give three adjectives to describe your relationship with your father as a young child:

Which parent do you feel closest to, and why?

When you were upset as a child, what did you do?

In general, how do you think your overall experiences with your parents have affected your adult personality?

Please summarize your current relationship with your parents.

Please summarize your religious/spiritual beliefs and the importance they play in your life.

Please summarize any major life changing events you have experienced which have positively or negatively affected you.



Current Trauma/Stressors (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Death of a significant person |
| <input type="checkbox"/> Relationship Difficulties | <input type="checkbox"/> Incarcerated family member |
| <input type="checkbox"/> Victim of trauma | <input type="checkbox"/> Health Problems |
| <input type="checkbox"/> Family Stressors | <input type="checkbox"/> Work related problems |
| <input type="checkbox"/> Other (please explain) | |
-
-

Interpersonal Problems (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Aggressive behavior | <input type="checkbox"/> Temper Outbursts | <input type="checkbox"/> Boundary Issues |
| <input type="checkbox"/> Alcohol or drug abuse | <input type="checkbox"/> Sexual Acting-Out | <input type="checkbox"/> Social Anxiety |
| <input type="checkbox"/> Other (please explain) | | |
-
-

Current struggles in our life that you would like to address in counseling. (Check all that apply)

Issues Related To Abuse

Career/Academic Issues

- | | |
|--|--|
| <input type="checkbox"/> Current or past physical abuse | <input type="checkbox"/> Colleague/Cohort problems |
| <input type="checkbox"/> Current or past sexual abuse | <input type="checkbox"/> Work performance |
| <input type="checkbox"/> Current or past emotional abuse | <input type="checkbox"/> Failing grades |
| <input type="checkbox"/> Current or past neglect | <input type="checkbox"/> Career dissatisfaction |
| <input type="checkbox"/> History of abandonment/rejection | |
| <input type="checkbox"/> History of family domestic violence | |



Mood Related Concerns

_____ **Disturbing Memories**

_____ **Sadness/Depression**

_____ **Suicidal Thoughts**

_____ **Feelings of guilt/shame**

_____ **Excessive Worrying**

_____ **Estranged Relationships**

Behavioral Concerns

_____ **Aggression toward others**

_____ **Drug/alcohol use**

_____ **Hyperactive/Impulsivity**

_____ **Betraying relationships**

_____ **Cutting**

_____ **Engaging in high-risk behaviors**

Family Relationship Concerns

_____ **Adjusting to family changes**

_____ **Parenting/Discipline concerns**

_____ **Parent/Child Relationship**

_____ **Divorce**

_____ **Separation**

Other Concerns

_____ **Sexual identity questioning**

_____ **Appetite eating concerns**

_____ **Sleep problems**

_____ **Stress management**

_____ **ADHD/ADD management**

_____ **Loneliness**

Other struggles you would like to address: Place a * by the most significant issues

Please summarize your current goals for counseling.

Client/Guardian Signature

Date