The Center for Integrative Counseling and Psychology

TheCenterCounseling.org | North Texas 214.526.4525 | Central Texas 254.732.2006

Adult Counseling Form

Date:

CLIENT INFORMATION:

Name: Nickname:

Gender: Birth Date: Age:

SSN: Address:

City/State/Zip Code: County:

Cell Phone: OK to leave message/text? Yes No

Home Phone: OK to leave message? Yes No

Work Phone: Ext: OK to leave message? Yes No

Email: OK to communicate via email* and Patient Portal? Yes No

OK to email tips on relational, emotional and spiritual health?* Yes No

*The Center will never send confidential personal information via email. We will not sell or distribute your email address in any way.

Employer: Occupation:

RELATIONSHIP STATUS:

Never Married Separated Married Marriage Annulled Living with Partner Widow/ Widower Divorced

Other Spouse/Partner's Name (if applicable):

RACIAL/ETHNIC BACKGROUND:

White Black or African American Asian Hispanic or Latino American Indian or Alaska Native Native Hawaiian or Other Pacific Islander

Other:

FAITH PREFERENCE:

Christian/Protestant Catholic Jewish Muslim Hindu Other:

Congregation Affiliation:

HIGHEST LEVEL OF EDUCATION COMPLETED:

Elementary School Middle School High School Some College Associate's Degree Bachelor's Master's Doctorate

Do you currently, or have you ever served in/ as:

Military Police/Law Enforcement First Responder None of these

REASON FOR VISIT:

What led you to seek counseling?

How long have you been dealing with this challenge? ☐ 0-6 months ☐ 6-12 months ☐ more than 1 year

What do you hope to gain from counseling?

Have you received previous counseling? If yes, please list when and with whom.

MEDICAL INFORMATION:

Any ongoing medical conditions? Please list:

Please list all current medications:

Physician: Phone: Fax:

Address: City/State/Zip:

OK to contact your Primary Care Physician (PCP)? ○ Yes ○ No

In case of concern for your safety or the safety of others, the counselor may decide to notify the emergency contact whom you designate. (Contact must be over 18 years of age.)

I acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment and prognosis to the following individual(s):

Name: Relationship:

Name: Relationship:

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: Phone:

Relationship:

REFERRAL:

How did you hear about The Center?

☐ Insurance/ EAP or Insurance/ EAP Website
☐ Psychology Today online listing
☐ Friend or family member
☐ Internet/ Google Search/ Social Media
☐ Doctor/Physician
Doctor/Physician Name
☐ Pastor or Church
Pastor or Church Name
☐ Workshop hosted or led by Center staff
☐ Other:
Please share

Notice of The Center Privacy Practices (HIPAA)

This notice tells you how we treat your health information, how we might disclose your health information to others, and how you can get access to the same information.

Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us and we want to do everything possible to protect that privacy.

We have a legal responsibility under the laws of the United States and the State of Texas to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice.

This notice takes effect on (April 14, 2003) and will be in effect until we replace it.

We have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in our privacy practices will effect how we protect the privacy of your health information. This includes health information we will receive about you or that we create at The Center. These changes could also effect how we protect the privacy of any of your health information we had before the changes.

When we make any of these changes, we will also change this notice and give you a copy of the new notice.

If you request a copy of this notice now or at any time in the future, we will give you a copy at no charge to you. If you have any questions or concerns about the material in this document, please ask for assistance which we will provide at no charge to you.

Here are some examples of how we may use and disclose your health information with your permission:

A. To your physician or other healthcare provider who is also treating you.

B. To anyone on our staff involved in your treatment program.

C. To any person required by federal, state, or local laws to have lawful access to your treatment program.

D. To receive payment from a third party for services we provide for you.

E. To be in compliance with Utilization Management/ Quality Improvement Plans by third parties.

F. To our own staff in connection with our Center's operations. Examples of this include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.

G. To anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you would like. When you revoke an authorization, it will only effect your health information from that point on.

H. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects your health information that are necessary to respond to the emergency.

We will not use your health information in any of our Center's marketing, development, public relations, or related activities without your written authorization.

We may not use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

As a client of The Center, you have these important rights:

A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.

B. You can ask us for photocopies of the information in part "A" above.

C. We will charge you a reasonable fee per page for making these photocopies.

D. You have a right to a copy of this notice at no charge.

E. You can make a written request to have us communicate with you about your health information by alternative

means, at an alternative location. (An example would be if your primary language is not spoken at this Center, and we are treating a child of whom you have lawful custody.) Your written request must specify the alternative means and location.

F. You may make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.

G. You may make a written request that we amend the information in part "A" above.

H. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information and anyone else of your choosing.

I. If we deny your amendment, you may place a written statement in our records disagreeing with our denial of your request.

J. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or our Center's operations. This can go back as far as six years.

K. If you request the accounting in "J" above more than once in a 12-month period, we may charge you a fee based on our actual costs of tabulating these disclosures.

L. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice, you may complain to us in writing to the following person:

Compliance Officer(s): CEO or
Clinical Director

Telephone: 214.526.4525 Fax: 214.520.6468

Address: The Center

4305 Mac Arthur Ave

Dallas, TX 75209

M. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

The Center Policy / HIPAA Acknowledgement and Therapy Consent

The Center for Integrative Counseling and Psychology (The Center) helps people of all ages across communities be self-aware, mindful and resilient to reach the potential of who they were created to be. We believe that, by developing awareness and gaining new insights and skills, people can grow through their struggles to live the life they were meant to lead. We address the health of the whole person: physically, mentally, emotionally and spiritually, honoring the role that spirituality and faith play in people's lives.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness because the process of psychotherapy often requires discussing the challenging aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Psychotherapy requires a very active effort on your part. Your participation in counseling, both in session and out of session, can help you achieve your goals for counseling.

NOTICE OF PRIVACY POLICIES:

The attached privacy policy tells you how we make use of your health information at our Center, how we might disclose your health information to others, and how you can get access to the same information.

Your relationship with The Center is important and confidential. Information cannot be released regarding your counseling without your written permission, unless disclosure prevents imminent harm or is required by state or federal law. Some examples include: suspected child or elder abuse; for third party payments such as insurance; if you are involved in a legal case where your therapist or the Center may be required by law to release your records to attorneys or judges; if you are dangerously close to harming yourself or others, your counselor may notify medical or law enforcement personnel; as described in the attached privacy policy.

LATE CANCELLATIONS AND MISSED APPOINTMENTS:

Initial appointments are generally 60 minutes. Follow-up appointments are generally 45-60 minutes. These sessions are reserved for you, and you are responsible for payment for that time. Cancellations received with more than 24 hours' notice will result in no charges being assessed. However, those canceling with less than 24 hours' notice will be charged $50 to the credit card on file. Repeat "no-show" or "late-canceled" appointments could result in termination of treatment. Insurance companies, EAP providers, or other responsible third-parties will not accept claims for missed or unused appointments.

THERAPIST ACCOUNTABILITY:

Your counselor's work is open to the scrutiny of professional supervision, peer review and the Licensing Boards in the state of Texas. If you have concerns or problems with your counseling relationship, or have questions about the Center's policies, you can talk directly with your counselor or The Center's CEO or Clinical Director. The consumer complaint hotline for most Texas licensed/ certified counseling professionals is 1.800.942.5540.

OUR LIMITATIONS:

We are an out-patient treatment center and cannot provide intense daily client monitoring. We are unable to help clients who:

- Continue to abuse alcohol and other drugs
- Misuse or refuse to use prescribed medication
- Require intense supervision
- Show disrespect to other clients, The Center staff or The Center property
- Are a danger to others or self

CONTACT INFORMATION:

To leave a message for your counselor you may go directly to the voicemail system by dialing 214.526.4525, then follow the directions for his/ her extension. These calls will be returned during normal business hours. For scheduling or billing questions, call Client Services at The Center's main number, 214.526.4525. In the event of of non life threatening crisis after regular business hours, call the National Suicide Prevention Hotline at 800-273-8255 or text HOME to 741741.

In case of an emergency, go to the nearest emergency room or call 911.

FEES/ FINANCIAL TERMS:

Fees are discussed during your first session. Payment is expected in full at the time of service. A credit card is kept on file for your convenience for payment of sessions or payment of fees for late cancellation or missed appointments. If unable to make payment at the time service is rendered, you will be asked to reschedule to a time when payment can be made. This enables us to remain fiscally sound and provide consistent, quality service. Insurance issues can be discussed with your counselor or our insurance coordinator. You are responsible for the balance due if your insurance does not pay for our services. You are also responsible for the balance if the insurance holder is different from yourself. If you have difficulties with your insurance company, you may file a complaint with the Texas Department of Insurance (1.800.252.3439 or www.tdi.state.tx.us).

CLIENT RECORDS:

There will be an administrative printing/ faxing charge of $25 for the first 20 pages and $.50 per page for every print thereafter for client records. Additional fees may include costs for record mailing, shipping or delivery. Please note it will take 7-10 business days for processing records. Charges for client records must be paid in advance and will be charged to the credit card on file.

LETTERS/ DOCUMENTATION:

There is a charge associated with any and all documentation we may have to complete. Charges will be determined by the amount of time spent to complete the request. Charges for letters/ documentation must be paid in advance.

COURT FEES:

This is not a service typically provided by The Center clinicians. If a deposition or opinion in court is required, there is a $200 per hour charge. The minimum charge is $1,600, to be paid in advance. Preparation, travel and attorney or clerk time is charged per hour. Travel cost (i.e. tolls, gas and miles) will also be billed. Your insurance company will not be billed for any of these fees; you are solely responsible for payment.

FMLA/ DISABILITY PAPERWORK:

The Center does not provide FMLA or Disability paperwork.

INSURANCE:

If you choose to use your insurance benefits, and your therapist is a PARTICIPATING PROVIDER (IN-NETWORK), you agree to assign payment from your health plan to The Center and to update The Center with your current insurance information at all times. If there

is a change in your insurance, we ask that you notify us of the changes at least two days prior to your appointment. Failure to do so may result in you being charged our standard rate per hour for your appointment. We will bill your insurance company if your therapist is an in-network provider. However, you are responsible for co-payments, deductibles and payments for services not covered or approved by your health plan at time (date) of service. If you have a deductible, you must pay each visit at the time of your appointment until the deductible has been met. If you are seen after regular business hours or on Saturday, you may incur an additional charge. If your insurance provider denies payment for any reason, you are responsible for payment. The Center does work with EAPs following the guidelines of your plan.

If you choose not to use your insurance benefits OR if you choose to use your insurance benefits, and your therapist is NOT A PARTICIPATING PROVIDER (OUT-OF-NETWORK), you understand that you are responsible for obtaining prior authorization/certification for treatment, and for submitting your claims for reimbursement from insurance. The Center will provide you with a receipt with all of the applicable information so you may attempt to obtain reimbursement for services, however, you will be responsible for the full fee at the time of service regardless of whether your insurance company reimburses you. Unfortunately, as The Center is not a contracted entity with your insurance company, you will be responsible for all communication with and attempts to obtain reimbursement from your insurance provider. If your insurance provider denies payment for any reason, you are responsible for payment, and your credit card on file will be used as the form of payment.

AGREEMENT:

I have read and understand my rights and obligations as a counseling client, including the HIPAA policy, late cancellations and missed appointments policy, and the limits of confidentiality of The Center. My signature below is my acceptance of policies and consent for psychotherapeutic services at The Center for myself/the Minor listed below and confirmation that my clinician reviewed the consents and releases with me.

Client Printed Name: _____ Date: _____

Client Signature:

_____

Client Consent - Internet or Telephone Counseling

I hereby consent to engaging in internet and/ or telephone counseling with The Center for Integrative Counseling and Psychology. I understand that these modes of service include the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of health care data, and I understand that internet and/ or telephone counseling also may involve the communication of my mental health/ health information, both orally and visually. I understand that encrypted phone lines are likely not used and therefore confidentiality cannot be guaranteed if sessions are conducted in areas with unsecure internet access (public WIFI). In addition, it is recommended that phone sessions occur in areas where you can assure privacy and not while running errands or in public areas. The clinician cannot assure confidentiality of information on the clients end (use of public WIFI, unsecure networks, speaking in public areas, etc.). In consenting to telecounseling I am agreeing to HIPAA compliant confidentiality and I will not capture any photos, video, or audio recordings of sessions.

I understand that I have the following rights with respect to internet and/ or telephone counseling:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

2. The laws that protect the confidentiality of my health care information also apply to internet and/ or telephone counseling. As such, I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

   I also understand that the dissemination of any personally identifiable images or information from the internet and/ or telephone counseling interaction to researchers or other entities shall not occur without my written consent.

3. I understand that there are risks and consequences from internet and/ or telephone counseling, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my health care information could be interrupted by unauthorized persons; and/ or the electronic storage of my health care information could be accessed by unauthorized persons.

   In addition, I understand that internet and/ or telephone counseling-based services and care may or may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits

associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse.

4. I understand that I may benefit from internet and/ or telephone counseling, but that results cannot be guaranteed or assured.

My signature below indicates that I understand the type and scope of information being disclosed as well as the risks associated with internet and telephone counseling, I have been offered the opportunity to ask questions regarding the use of this information, and I consent to internet and telephone counseling.

Client Printed Name: Date:

Client Signature: