Adult Assessment Form

Date: _____

CLIENT INFORMATION:

First Name: _____ Middle Name or Initial: _____ Last Name: _____

Nickname: _____ Gender: ☐ M ☐ F ☐ Other _____

Birth Date: _____ SS#: _____

Address: _____

City: _____ State: _____ County: _____ Zip Code: _____

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

Home Phone: _____ OK to leave message? ☐ Yes ☐ No

Work Phone: _____ Extension: _____ OK to leave message? ☐ Yes ☐ No

Email: _____ OK to communicate via email regarding scheduling? ☐ 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 ☐ Married ☐ Living with Partner ☐ Divorced

☐ Separated ☐ Marriage Annulled ☐ Widow/Widower ☐ 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

Adult Assessment Form (continued)

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 testing? _____

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 testing? _____

Have you received previous counseling or testing? 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.)

Emergency Contact Name: _____ Phone: _____

Relationship: _____

REFERRAL: How did you hear about The Center?

☐ Insurance/EAP or Insurance/EAP Website
☐ Friend or family member
☐ Doctor Name: _____
☐ Workshop hosted or led by Center staff
☐ Psychology Today Online Listing
☐ Internet/Google Search
☐ Pastor or Church Name: _____
☐ Other: _____

03.2020

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
4525 Lemmon Avenue, Suite 200
Dallas, TX 75219

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.

03.2020

The Center Policy/HIPAA Acknowledgement and Informed Consent Form - Testing/Assessment

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.

This consent form provides information about our assessment services and about your rights and responsibilities as a client. Please be sure to discuss any questions with your clinician or his/her supervisor. Your signature at the bottom of the form indicates that you understand the information and freely consent to participate in this assessment.

THE ASSESSMENT PROCESS: Through the use of standardized psychological tests or screening devices, we attempt to assess questions related to diagnosis, personality functioning, coping styles, intellectual ability, academic achievement and/or vocational interests. Throughout the assessment, you have the right to inquire about the nature and purpose of all procedures administered to you. Once completed, you will be informed of the results, interpretation and/or recommendations. A licensed psychologist, post-doctoral psychology fellow, or a pre-doctoral psychology intern will conduct your assessment. You will be advised if the clinician administering the assessment is doing so under supervision and you will be provided with the name and contact information of the supervisor.

The assessment process generally begins with a clinical interview followed by the administration of one or more psychological, educational, intellectual, vocational, and/or screening measures. Although it is sometimes possible to complete the testing procedures in one day, it is common for individuals to return for further sessions in order to complete the assessment battery. The total time of the evaluation may vary, but on average the testing procedures take 4 to 8 in-person hours to complete. The individual may experience emotional distress because of the personal nature of some of the information solicited by the testing process. You or the individual being tested may interrupt or discontinue this testing process at any time. Please be aware that if the testing is interrupted the clinician may be unable to give feedback or complete a written report.

Once the testing phase is finished, the data will be analyzed and a report written. In some instances, however, results will be reported orally and not in writing. The general completion time for oral and written reports is 2 to 4 weeks. At this time, a feedback session will be scheduled to go over the results.

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.

CONFIDENTIALITY: Your relationship with The Center and the information contained in the assessment is confidential and will not be released to any person or organization without your written permission. In situations where the assessment is being requested by a third party you will have to sign a full release of information to that third party to release the report.

There are circumstances where state and/or federal law require that confidentiality be put aside and your information shared with others without your consent. These are:

1. Allegations of abuse, neglect or sexual abuse. Texas law requires all clinicians who have a cause to believe that a child has been, or may be, abused, neglected, or sexually abused, to make a report of such within 48 hours to the Texas Department of Family and Protective Services, the Texas Youth Commission or to any local or state law enforcement agency. If the clinician has cause to believe that an elderly or disabled person is in a state of abuse, neglect or exploitation, this must be immediately reported to the Texas Department of Family and Protective Services.

2. Serious threat of danger to self or others. If the clinician determines that there is a probability of imminent physical injury by you or your child(ren) to yourself or others, or there is a probability of immediate mental or emotional injury to you, the clinician may disclose relevant confidential mental health information to medical or law enforcement personnel.

3. Court order and/or subpoena. Court-ordered subpoena can require the release of records kept at the counseling Center or require a clinician to give testimony at a court hearing.

Continued on next page | Client Initials _____

The Center Policy/HIPAA Acknowledgement & Informed Consent Form - Testing/Assessment (cont)

4. Sexual exploitation or abuse. Texas law requires a clinician to report client abuse or sexual exploitation by a previous therapist to the appropriate county district attorney and licensing board. Client anonymity will be preserved if requested.

In the rare event that one or more of these circumstances arise, we will, if appropriate, attempt to discuss these responsibilities with you before complying with our obligation under the law.

INSURANCE: If you choose to use your insurance benefits, and the clinician **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 by your health plan. If you have a deductible, you must pay each visit at the time of your appointment until the deductible has been met.

Please be aware that if you plan to have the center file for reimbursement with a managed care or insurance company, the managed care or insurance company may require information about the diagnosis and treatment records. Since this information will become part of your insurance file, you may wish to contact your insurance carrier to learn about their requirements and ensure that you are comfortable with the nature of the information that will need to be released in order to receive payment.

If you choose not to use your insurance benefits OR if you choose to use your insurance benefits, and the clinician **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.

If you have concerns or problems with the testing experience, or have questions about the Center's policies, we hope that you will talk directly with your clinician and his/her supervisor. You may also talk to the Center's Clinical Director. The consumer complaint hotline for most Texas licensed/certified counseling professionals is 1.800.942.5540.

FEE AND PAYMENT POLICY: Fees are discussed during the intake session unless already agreed upon. Fees are determined based on the complexity and number of measures used and the time required by the clinician to provide an accurate evaluation or screening. Fees generally range between $400 and $3,500. In rare instances, the clinician may deem it necessary to request further testing beyond that agreed upon at the beginning of the assessment process. At that time, you will have the right to accept or decline the additional procedures.

In some cases (including career testing) you are required to pay your fee in full prior to testing. For most other assessments, you are required to pay 50% of your fee prior to testing and the remaining balance is due prior to the feedback session.

This enables us to remain fiscally sound, and therefore provide consistent quality service. Insurance issues can also be discussed with your clinician or with 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 can file a complaint with the Texas Department of Insurance (800.252.3439 or www.tdi.state.tx.us).

Please initial here that you understand your financial responsibility: _____

Estimate of fees: $ _____ *(to be completed by clinician at intake session)*

Continued on next page | Client Initials _____

The Center Policy/HIPAA Acknowledgement & Informed Consent Form - Testing/Assessment (cont)

LATE CANCELLATIONS AND MISSED APPOINTMENTS: Sessions are generally scheduled for 60 minutes to 5 hours. Testing session durations vary. The appointment you schedule is reservedhfor you. You will be billed for missed appointments and cancellations of less than 24 hours' notice. Cancellations received with more than 24 hours' notice will result in no charges being assessed. However, those cancelling with less than 24 hours' notice will be charged $250 to the credit card on file. Insurance companies, EAP providers, or other responsible third-parties will not accept claims for missed or unused appointments.

Please initial that you understand The Center's late cancellation and missed appointment policy: _____

OPTIONAL CONSENT FOR AUDIO RECORDING: Some testing measures allow the clinician to audio record your responses in order to be reviewed again at the time the assessment is interpreted.

Please initial here if you give permission for this audio recording: _____

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.**

AGREEMENT: To provide the best possible care, your clinician's work is open to the scrutiny of professional supervision and peer review. The Center follows state and federal laws regarding the electronic transmission of records.

I have read and understand my rights and obligations as an assessment client as well as the limits of confidentiality of The Center. I consent to the assessment for my child, my adolescent, legal ward, or myself and agree to make at least partial payment prior to the beginning of the testing process.

Client Printed Name: _____ Client Signature: _____ Date: _____

Or for Minor

Parent/Guardian Printed Name: _____ Parent/Guardian Signature:_____ Date: _____

I have legal authority to sign this on behalf of _____ Relationship: _____
(Name of Minor)

03.2020

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.).

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: _____ Client Signature: _____ Date: _____

Or for Minor

Parent/Guardian Printed Name: _____ Parent/Guardian Signature:_____ Date: _____

I have legal authority to sign this on behalf of _____ Relationship: _____
(Name of Minor)