Garland's Christian Counseling Center

PERSONAL DATA

Date:

Name: Email: Home Phone:

Address: Cell Phone: Work Phone:
(Street, City, Zip Code)

DL #, ST & Exp Date: SS#: DOB: Sex:

Please circle where we may leave a message: Home Cell Work Email

Occupation: Employed by: How Long?

Highest Level of Education Completed: Current Church Denomination Preference:

Church You Currently Attend: Church Denomination in Childhood:

Marital Status: Single In a Relationship Married Separated Divorced Widowed

Name of Spouse/Significant Other: Years Married/Together:

List Any Previous Marriage/Serious Relationship *(Name of Spouse/Significant Other, Years Together, Years apart, and Do You Still Keep In Contact With Them?):*

List All of Your Children/ Name Of Child	DOB:	Sex: M F	Living? Y N	Highest Grade Completed:	Marital Status:	Do They Live with You? Y N	Keep in Contact? Y N	From Current/Previous Relationship

3112 North Jupiter Road, Ste 203, Garland, TX 75044, Phone: 972-897-4986, Fax: 214-703-9977

List All Of Your Siblings/ Name of Sibling:	DOB:	Where Do They Live?	Living? Y N	Healthy? Y N	Keep In Contact? Y N	Same Dad? Y N	Same Mom? Y N

Health Status: Rate Your Health: Very Good Good Average Declining Poor

Recently Weight Changes: Lost: lbs, Gained: lbs,

Name of Your Physician: Dr. Office's Phone #:

List Any & All Medications You Are Currently Consuming *(Name, Dosage, & Frequency):*

List All Important Present or Past Illnesses/Injuries/Handicaps:

Have You Ever Been Hospitalized For Mental Illness or Substance Abuse? *If yes, List the Name of the Hospital, Phone#, Dates/# of Days for Stay, Reason for Hospitalization, & Was the Hospitalization Helpful in Resolving Your Issue?*

Have You Ever Had or Are You Currently Attending Any Psychotherapy or Counseling Sessions? *If yes, List the Clinician's Name, Phone #, Dates/# of Sessions You Completed with Them, Issue You Sought Assistance For, & Was the Sessions Helpful in Resolving Your Issue?*

What's going On In Your Life That Made You Seek Counseling At This Time?

Payment Method: Circle who is responsible for payment: **Self** **Relative** **Insurance Carrier**

Name of Insurance Carrier/Plan:

Name of the Insured:

Insured's Address:
(Street, City, Zip Code)

Insured's Phone #:

Insured's DOB:

Insured's ID# & Group # or Claim # or Case #:

Insured's Employer:

Who Can We Contact in the Metroplex In Case of Emergency?

Name:

Relationship to Self:

Address:
(Street, City, Zip Code)

Home Phone #:

Cell/Work Phone #:

Name:

Relationship to Self:

Address:
(Street, City, Zip Code)

Home Phone #:

Cell/Work Phone #:

How Did You Hear of About Us?

I solemnly swear that all of the information given on this form is true, to the best of my knowledge. I understand if any of the information given changes, I will advise the office of Garland's Christian Counseling Center before my next appointment.

_____

Signature of Client **Date**

Garland's Christian Counseling Center

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.

OUR COMMITMENT TO YOUR PRIVACY

We understand that medical information about you and your health is personal and we are committed to protecting that information. We create a record of your benefits, eligibility status and claims history. We need this record to provide you with quality health care services and to comply with certain legal requirements. Hospitals, physicians and other health care providers providing health care services to you may have different policies or notices regarding their uses and disclosures of your medical information. This Notice will tell you about the ways in which we may use and disclose medical information to you. This Notice will also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to make sure that medical information that identifies you is kept private; give you this Notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION TO YOU

We will not disclose your medical information to anyone, except with your authorization or as otherwise permitted or required by law. For some activities, we must have your written authorization to use or disclose your medical information. However, the law permits us to use or disclose your medical information for the following purposes without your authorization:

Payment: We may use and disclose your medical information in order to obtain payment for your medical treatment. These activities may include making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you to determine medical necessity, and undertaking utilization review or case management activities with respect to your claims. For example, we may use and disclose your medical information to obtain payment for your provided treatment.

Health Care Operations: We may use or disclose medical information about you for our insurance and pre-authorization operations. These uses and disclosures are necessary to run the clinic and make sure that you receive the treatment your physician has prescribed for you. Here are some examples of the ways that we use your medical information for our health care operations:

- Disclosures to medical consultants to determine the medical necessity of treatment recommended by your physician;
- Recovery of payments;
- Conduct of reconsiderations and appeals; and
- Disclosures to insurance networks for purposes of negotiating payment for services rendered.

As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law. We may also share your medical information with the Secretary of the Department of Health and Human Services to investigate or determine our compliance with federal privacy laws.

To advert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Special Situations: We also may use or disclose your protected health information in the following special situations <u>without</u> your authorization. These situations include:

- **Health Oversight**

We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Health oversight agencies include federal and state government agencies that oversee health service entities, and certain other government regulatory programs.

- **Public Health Risks**

We may disclose medical information about you for public health activities. These activities may include (1) the prevention or control of disease, injury or disability and (2) notifying people of recalls of products they may be using.

- **Lawsuits and Disputes**

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

- **Law Enforcement**

We may release medical information if asked to do so by a law enforcement official: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) to identify or locate a suspect, fugitive, material witness or missing person; (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; or (5) in emergency circumstances to report a crime, the location of the crime or victims, or the identity , description or location of the person who committed the crime.

- **For Specific Government Functions**

We may disclose your medical information for the following specific government functions: (1) health information of military personnel, as required by military authorities; (2) health information of inmates, to a correctional institution or law enforcement official; and (3) for national security reasons.

- **Worker's Compensation**

We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

YOUR RIGHTS

The following is a statement of your rights with respect to your medical information and a brief description of how you may exercise these rights.

You have the right to inspect and receive a copy your medical information. You may inspect and obtain a copy of medical information about you for as long as we maintain the medical information. We may charge you a fee for the costs of copying, mailing or other supplies that are necessary to grant your request. You have the right to choose to obtain a summary instead of a copy of your medical information. **Under federal law, however, you may not inspect or copy psychotherapy notes or psychological evaluation information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding.** In some circumstances, you may have the right to have our decision to deny you access to your medical information reviewed. Please contact our office if you have any questions about access to your medical information.

You have the right to request a restriction on the use and disclosure of your medical information.

You have the right to request restrictions on certain uses and disclosures of your medical information. We are not required to agree to a restriction that you request. If we do agree to requested restriction, we will put the agreement in writing and follow it, except in emergency situations. We cannot agree to limit uses or disclosures of information that are required by law. You may request a restriction by writing to or telephoning our office.

You have the right to request to receive your medical information by alternative means or at an alternative location. You may request that any and all of your medical information be sent by alternative means or to an alternative location. For example, you may request that we contact you only in writing or at a different residence or post office box. We will accommodate reasonable requests. We may condition that we permanently send your

medical information to that alternative location or by the alternative means. We will not request an explanation from you as to the basis for the request. Please make any such requests in writing to our office.

You may have the right to have your medical information amended.
You may request that we amend your medical information that is incorrect or incomplete for as long as we maintain the information. In certain cases, we may deny your request for amendment. You have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and provide you with a copy of such rebuttal. Any statement of disagreement will become a permanent part of our records. To request an amendment, you must send a written request, along with the reason for the request, to our office.

You have the right to receive an accounting of certain disclosures of your medical information.
You have a right to receive an accounting of disclosures of your medical information we have made after April 14, 2003 for purposes other than disclosure for (1) our treatment, payment or health care operations, (2) you or based upon your authorization and (3) certain government functions. To request an accounting, you must submit a written request to our office. You must specify the time period, which may not be longer than six years.

You have the right to disclose you medical information.
Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your authorization. If you provide us with permission to use or disclose medical information about you by signing a written authorization, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

You have the right to a paper copy of the Notice.
You have the right to obtain a paper copy of this Notice from us upon request. To obtain a paper copy of this Notice, please contact our office.

QUESTIONS ABOUT THIS NOTICE

If you have any questions about this Notice, please contact our office by calling 972-897-4986 or writing to Attn: Garland's Christian Counseling Center's Privacy Practice, P.O. Box 452244, Garland, TX 75045-2244.

CHANGES TO THIS NOTICE
We reserve the right to change this Notice. We reserve the right to make the revised Notice effective for the medical information we already have about you, as well as any information we receive in the future.

COMPLAINTS
You may contact us or the Secretary of the United States, Department of Health and Human Services, if you believe your privacy rights have been violated. To file a complaint with Garland's Christian Counseling Center contact our office. All complaints must be submitted in writing. No retaliatory actions will be taken against you for filing a complaint.

_____ _____
Patient/Client Signature Date

_____ _____
Patient/Guardian/Parent Signature Date

Garland's Christian Counseling Center

CONSENT FOR TREATMENT

THE GARLAND'S CHRISTIAN COUNSELING CENTER MISSION:
GARLAND'S CHRISTIAN COUNSELING CENTER is dedicated to helping individuals, marriages & families to heal, grow, and change. We assist our clients in stopping the anxiety, frustration, sadness & pain by providing individual, martial or family counseling sessions in a professional manner.

TREATMENT:
Services are provided at the direction of your physician and/or with discussion with a prospective client. Clients of GARLAND'S CHRISTIAN COUNSELING CENTER behavioral health services must be aware that individual psychotherapy, group counseling, and hypnotherapy may produce internal changes and clients often experience a surge of intense feelings. Clients should be aware of this stress upon themselves and upon their relationships, which might occur during the course of treatment. In addition, there is no guarantee that treatment will be successful, as individuals respond differently to therapeutic approaches. GARLAND'S CHRISTIAN COUNSELING CENTER offers a wide range of behavioral health services, but in some cases, other clinical providers, medical providers, hospitals, community programs, and/or community centers may assist in treatment. Treatment duration and frequency will vary depending upon the presenting problems.

CONSENT FOR TREATMENT:
I acknowledge that I have received, have read (or have had read to me), and understand the therapy I may engage in, and I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment through GARLAND'S CHRISTIAN COUNSELING CENTER.

I understand and agree that no promises have been made to me as to the results of treatment or of any procedures provided by the therapist.

I am aware that I may stop my treatment with the GARLAND'S CHRISTIAN COUNSELING CENTER therapist at any time. I understand and agree that I may lose other services or may have to deal with other problems if I stop treatment before goals are attained. (For example, if my doctor has directed my treatment, I will have to answer to him/her and/or the insurance payer, regarding my self-termination of treatment).

I understand and agree that I must call to cancel an appointment at least 24 hours before the appointment. If I do not cancel my appointment at least 24 hours before the appointment, or do not show up for the appointment, my treating doctor and/or my insurance payer will be advised.

I understand and agree I will be assessed a $40 no show fee, if 24 hours notice isn't given for cancelled appointments or for any appointments that I didn't show up for. I understand that this fee must be paid before another appointment will be scheduled.

I understand and agree that payment for my treatment is due at every session, in the amount of _____, for a _____ minute session. I understand and agree that if payment for the services I receive here is not made, that the GARLAND'S CHRISTIAN COUNSELING CENTER therapist may stop my treatment and make outside referral as necessary.

I understand that GARLAND'S CHRISTIAN COUNSELING CENTER accepts payment by MasterCard/Visa Credit/Debit Card, exact cash or personal check.

I understand and agree that if my check is returned by my bank for insufficient funds that I will have to pay a $40 returned check fee before my next appointment and replace the funds the NSF check was originally written for. In addition, I understand and agree that my personal checks will no longer be accepted as a form of payment for my treatment at GARLAND'S CHRISTIAN COUNSELING CENTER.

I understand and agree to inform my therapist at GARLAND'S CHRISTIAN COUNSELING CENTER of any changes to my insurance coverage while I am in therapy.

I understand and agree that I am personally responsible for the cost of the services rendered to me, including but not limited to: all co-pays, unmet yearly deductibles charged by insurance provider, any fees or portions of fees not paid by my insurance carrier and that GARLAND'S CHRISTIAN COUNSELING CENTER can not legally nor ethically waive them at any time.

I understand and agree that payment for any services rendered, that are funded by my insurance policy, that such benefits will be assigned from me to GARLAND'S CHRISTIAN COUNSELING CENTER as my form of payment for such services that were rendered. I permit a copy of the signature on this release to serve as a lifetime authorization. A copy of this release may be used in place of the original.

I understand and agree payments for services rendered are expected at the time services are rendered. Failure to keep payments current by insurance will result in collection action for the balance due.

I agree to pay GARLAND'S CHRISTIAN COUNSELING CENTER for all services rendered and attest I have been informed of said charges.

I agree that I will leave my cell phone, pager and or/other two-way communication device in the "off" or "silent" mode during counseling sessions.

I understand and agree that in group/family therapy settings, individual privacies are maintained to the best extent possible.

I understand that all of the GARLAND'S CHRISTIAN COUNSELING CENTER therapists have at a minimum a Master's degree or are graduate intern/practicum students and have had the proper training and credentialing for the provision of services that they provide.

I am aware and agree that my doctor, an agent of my insurance company, other third-party payer, or my legal representative may be given information about the type(s), cost(s), date(s), and the providers of any services or treatments I receive.

I understand and agree that my doctor, an agent of my insurance company, other third-party payer, and/or my legal representative will be given reports containing information about my progress and participation in treatment from GARLAND'S CHRISTIAN COUNSELING CENTER.

I understand and agree that I will not receive copies of my progress notes from GARLAND'S CHRISTIAN COUNSELING CENTER, if it is suspected that the information obtained could prove harmful to me. I understand and agree that I will not receive copies of my progress notes from GARLAND'S CHRISTIAN COUNSELING CENTER unless reviewed between a clinician and myself and to do so will warrant scheduling an appointment.

I understand and agree that Information about myself, including case records, will be released under the following conditions:

a) The GARLAND'S CHRISTIAN COUNSELING CENTER therapist is using case records for purposes of supervision, professional development, or training and research. In such cases, to preserve confidentially, clients will be identified by first names only;
b) The GARLAND'S CHRISTIAN COUNSELING CENTER therapist determines that the client is a danger to himself/herself or to someone else;
c) The client discloses abuse, neglect, or exploitation of a child, elderly, or disabled person;
d) The client discloses sexual contact with another mental health professional with whom the client had/has a professional relationship;
e) The GARLAND'S CHRISTIAN COUNSELING CENTER therapist is ordered by a court to disclose information;
f) The client directs GARLAND'S CHRISTIAN COUNSELING CENTER therapist to release the client's records;
g) The GARLAND'S CHRISTIAN COUNSELING CENTER therapist is otherwise required by law to disclose information.

I understand and agree that should I have a complaint regarding any of the treatment that I receive through GARLAND'S CHRISTIAN COUNSELING CENTER, I may inform the therapist that I am working with. If I wish to go beyond this level of complaint, I may advise my treating physician and/or insurance provider, ask the office staff for higher remedies, and/or contact the State Board of Examiners for Licensed Professional Counselors at 1-800-942-5540.

I agree that a photocopy or fax transmission of this form is acceptable, but that it must be individually signed by me. I understand that I have a right to receive a copy of this form upon my request.

_____ _____
Patient/Client Signature Date

_____ _____
Patient/Guardian/Parent Signature Date