Garland Counseling Center

310 E Interstate 30, Ste M107, Garland, TX 75043
(o) 469-687-0200 (f) 469-687-0137
www.GarlandCounselingCenter.com

Client Demographic Information:

Client's Name: _____ Date of Birth: _____

Phone #: _____ Social Security #: _____

Email address: _____ Driver's License #: _____

Address: _____ (Street) Gender: _____

_____ (Apt#) Race/Ethnicity: _____

_____ (City, Zip) Marital status: _____

Sexual Orientation: _____ Religious Preference: _____

Highest level of education: _____ Military status: _____

Employment status: _____

Living situation: _____ #/Ages of children: _____

Emergency Contacts:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

If client is a minor, please complete parents/legal guardians' information below:

Parent/Guardian Name #1: _____ Phone #: _____

Address: _____ Email: _____

Parent/Guardian Name #2: _____ Phone #: _____

Address: _____ Email: _____

Referral source: How did you hear about us? _____

I consent to financial, appointment and welfare communication from this office as follows:

____ Yes/No -- Phone call

____ Yes/No -- Phone text

____ Yes/No -- Email

Signature: _____ Date: _____

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Confidentiality and Counseling Agreement:

Confidentiality and access to records: All counseling sessions and records are confidential and accessible within 21 days with a signed, written request. Some information is NOT confidential:

1. Child abuse, Elder abuse, or abuse of a protected person MUST be reported, by law.
2. If you are a danger to yourself or others—some examples include suicidal thoughts with a plan, homicidal thoughts with a plan, severe psychosis, severe self-harm, or severe drug/alcohol use.
3. Courts may subpoena records for the past 5 years.
4. If you are seeing an LPC Associate, your case will be discussed with the Associate's Supervisor.
5. Government agencies and insurance companies may audit records for compliance. Your record may be used if there is a legal or ethical dispute.

Risks & Benefits: While most people report the benefits of counseling far outweigh the risks, you should be aware that there are some risks in counseling: You may experience some uncomfortable feelings while discussing difficult topics. Personal change can be uncomfortable. Relationships may change as you change—this may be a wanted or an unwanted change. Benefits of counseling may include the following: Increased awareness of feelings and thoughts, increased coping skills, improved mood, and improved relationships. There are no guarantees in counseling, but most people find counseling helpful.

What to expect: Counseling sessions begin at the specified time and last 45-50 minutes. If you are late for your appointment, you will have a shorter session—your appointment will still end at the specified time. Full payment for each session is expected at the beginning of each appointment.

Your session time is reserved for you. If you are unable to make your appointment, please notify the counselor **AT LEAST 24 HOURS** in advance, so that this time can be given to someone else. If you fail to give this notice, you must pay for the missed session within (7) days.

Children under 12 years of age must be supervised by an adult in the waiting area. No smoking is allowed in the building. No drugs, firearms, or other weapons are allowed on the premises. Clients agree not to attend counseling under the influence of drugs or alcohol.

Complaints: Complaints may be directed to the following:
CONSUMER COMPLAINT HOTLINE: 1-800-821-3205
Texas Behavioral Health Executive Council
George HW Bush State Office Building – 1801 Congress Ave, Ste 7.300
Austin, TX 78701

I **consent** to receive and pay for counseling services with the Counselor/Associate named below.

Client's name: _____ Date of Birth: _____

Client's/Guardian's signature: _____ Date: _____

Counselor's name & signature: _____

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Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____, and me/us, Garland Counseling Center. When we use the words "you" and "your" below, this can mean you, your child, or a person for whom you are the legal or personal representative if you have written his or her name here: _____ .

When we examine, evaluate, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide what treatment is best for you and to provide this treatment to you. We may also share this information with others to arrange payment for your treatment, to help others provide other treatment to you, or to carry out certain business or government functions.

By signing this form, you are agreeing to let us use your PHI here and to send it to others for the purposes described just above. Your signature below acknowledges that you have read or heard our Notice of Privacy Practices, which explains in more detail what your rights are and how we can use and share your information. If you do not sign this form agreeing to our privacy practices, we cannot treat you, because we need to use your PHI to evaluate, diagnose, and treat you.

In the future, we may change how we use and share your PHI, and so we may change our Notice of Privacy Practices. If we do change it, you can get a copy from our compliance officer, Delene Penix, who can be reached at 469-687-0200 and delenecounselor@gmail.com.

After you have signed this consent, you have the right to revoke it by writing to our compliance officer. We will then stop using or sharing your PHI, but if we have already used or shared some of it, and we cannot change that.

_____ ___/___/___

Signature of client or personal representative — Date

_____ _____

Printed name of legal representative — Relationship to client

_____

Description of personal representative's authority

_____

Signature of authorized representative of this office or practice

❑ Copy given to the client/parent/personal representative 02/02/2020

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Notice of Privacy Practices (Brief Version)

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

As part of providing professional care to you, we will do all we can to maintain the privacy of what is called your "protected health information" (PHI). We are also required by law to keep your PHI private. These laws are complicated, and we must give you this important information. This page is a shorter description of what we do to maintain your privacy. If you would like to read the more detailed version, please ask any staff member for a copy. If you have any questions about our practices, please contact our compliance officer, whose information is listed at the bottom of this page.

How we use and disclose your protected health information (PHI) with your consent

We will use the information we collect about you mainly to provide you with treatment; to arrange payment for our services; and for some other business activities called, in the law, "health care operations." We will ask you to sign a separate consent form to show that you understand these ways we handle your information. If you do not agree and won't sign this consent form, we will not treat you. If we want to use or send, share, or release your PHI for other purposes, we will discuss this with you so you fully understand it, and ask you to sign a release-of-information form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to share your information without getting your consent. They are described in the longer version of our Notice of Privacy Practices, but here are the most common situations:

1. When there is a serious threat to your or another person's health or safety or to the public. We will only share information with people who are able to help prevent or reduce the danger.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. When a law enforcement official requires us to do so.
4. For workers' compensation and some similar programs if you seek these benefits.

Your rights about your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, rather than at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical chart, case file, and billing records. You can get a copy of these records, and we can charge you for it. Please talk to our compliance officer to arrange how to see your records.
4. If you believe that the information in our records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our compliance officer.
5. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our compliance officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.
6. You have the right to a copy of this notice.

Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. Our compliance officer will be happy to discuss these situations or answer any questions now or as they arise.

Here is the officer's name and contact information:

Delene Penix, 469-687-0200, delenecounselor@gmail.com. The effective date of this notice is 02/02/2020.

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Consent for Release of Information:

+For the purpose of coordination of care (COC), coordination of insurance/disability benefits (COB), emergency (E), or other _____.

***Dates are typically date of admission through date of discharge, unless otherwise specified.*

Name	Relationship *Family, friend*	Phone #	Address (city)	**Consent? Yes or No**	+Purpose: COC, COB, E, Other	**Dates:
	Insurance Co.	Ph:	PO Box # _____ City: _____ State: _____		COB	
	Disability Co.	Ph:	Claim #: Care mgr:		COB	
	PCP/Dr.	Ph:			COC	
	Psychiatrist	Ph:			COC	
	Specialist	Ph:			COC	
	Spouse/Partner					

I, _____ (Client's name or Legal representative), do hereby authorize Delene Penix, LPC and/or Abigail Alford, LPC to disclose records and/or information concerning _____ (Client) to the above names, persons or organizations.

Such disclosure shall include the complete record unless otherwise indicated.

Initial: _____ I understand this disclosure may also include any information related to AIDS/HIV status and/or substance use/disorders.

Client's signature: _____ Date: _____

Client's date of birth: _____ Client's Social Security #: _____

Legal Representative's signature: _____ Date: _____

Witness signature: _____ Date: _____

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Financial Information Form

If you have health/mental health insurance, it may pay a part of the cost of your services here. Please, **initial** to indicate your payment preference and agreement:

___ I elect to use my health/mental health insurance benefits to pay part of the cost of counseling and will pay my financial responsibility (co-pay, deductible, and/or co-insurance.)

___ I prefer to pay the private fee of $____ per session.

Please, **initial** each of the following to indicate understanding and agreement**:**

____ I agree to **pay a fee of $100 if I arrive later than 20 minutes for my appointment**—these services can't be billed to insurance.

____ If I must miss my scheduled appointment, I agree to notify the office as soon as possible and **pay $50** if I fail to **cancel** my appointment **at least 24 hours in advance**.

____ I agree to pay **$35 fee** per returned check.

Release of information and assignment of benefits:

I, the client (or the policy holder), by my signature below authorize the release by this office of any information obtained during evaluations and treatment that is necessary to support and process any insurance claims, determine medical necessity, support any clinical or financial audits, or requests for additional sessions. I hereby assign medical/mental health benefits, including those from government-sponsored programs and other health plans, to be paid to the clinician or business below. Medicare regulations may apply.

I understand that insurance may not cover some services and that I am responsible for all charges, regardless of insurance coverage or other payments.

I understand that some services are not covered by insurance (including, but not limited to, cancelled appointments, late appointments**,** court appearances and phone appointments.)

A photocopy of this assignment is to be considered as good as the original.

Client's (or policy holder's) signature _____ Date: _____

Client's printed name _____

My signature indicates my agreement to and accuracy of all of the statements above.

Clinician's signature _____ Date: _____

Clinician's printed name, title, & license #: _____

Business owned by Julie Delene Penix dba Garland Counseling Center

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Current Symptoms (in the past 2 weeks):

(Please circle all that apply)

Mood: Depressed, down, hopeless, worthless, guilty, low self-esteem, anxious, worried, tense, stressed, overwhelmed, fearful, panic, elated, happy, high self-esteem, confident, mood swings, angry, irritable, frustrated

Behavior: Unmotivated, change in appetite or weight, sleeping too much or too little, change in energy level, difficulty focusing or making decisions, recurrent thoughts of death, excessive/loud/fast speech, distractible, racing thoughts, risky or reckless behavior, increase in activity level, repetitive/intrusive thoughts or images, repetitive/compulsive behaviors, panic attacks, on high alert for danger, increased/excessive/problematic alcohol/drug use, anger outbursts, throwing things, aggressive

Psychosis: Seeing/Hearing things that others don't see/hear, Thinking that someone is watching you/plotting against you/following you, Thoughts or beliefs that others find disturbing or not grounded in reality, History of psychosis

Risk: Suicidal thoughts, Wishing you were dead, Having no sense of purpose in life, History of suicide attempt, Self-harm behaviors (cutting, burning, scratching, head-banging), Self-harm urges/thoughts, History of self-harm behaviors, Homicidal thoughts/Wanting to kill or seriously injure another person, Access to a firearm, Agree to safety, Family member or friend who committed suicide

Reason you are seeking counseling: _____

_____

_____

_____

_____

What are your goals for counseling: (What do you want to be different when we finish?)

_____

_____

_____

_____

What are your personal strengths? _____

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Personal History

Allergies & Reaction: _____

Medical conditions: _____

Current medications: (Attach list, if needed)

Name	Reason	Dose	Frequency	Take as directed?

Who is supportive? _____

Exercise: Yes/No --Type of exercise? _____ How often? _____ How long? _____

Nutrition: Healthy, Normal, Bingeing, Purging, Laxative/Diuretic use, Over/Under-eating, Eating Disorder

Sleep: # of hours daily = _____ Sleep problems: Trouble falling/staying asleep, Naps, Nightmares

Hobbies: _____

Legal issues: _____

Drug/Alcohol use: _____

Nicotine/Tobacco use: _____ Caffeine use: _____

Past surgeries: _____

Past hospitalizations: _____

Past psychiatric treatment: _____

Trauma history (circle all that apply): Physical abuse &/or Sexual abuse

Witnessing or Experiencing Murder/Suicide/Rape/Life threatening accident/Natural disaster

Your age at time of trauma: _____

How did you know your abuser(s) and was it reported?: _____

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Family History

Who did you grow up with in the home? Mom, Dad, Step-mom, Step-dad, Brothers (#__), Sisters (#__), Grandmother, Grandfather, Aunt, Uncle, Other_____

Are your parents living? _____ Are your siblings living? _____

How would you describe your parents? _____

If you have any siblings, what is your birth order? _____

Briefly describe any relationship issues within the family:

_____

_____

Chronic, severe, or terminal illness: (who & what)

_____

Developmental, neurological, intellectual disorders: (who & what) (examples: autism, ADHD, Down's)

_____

Mental Illness: (who & what)

_____

_____

Chemical Dependency: (who) _____

Suicide/Attempt: (who) _____

Abandonment: (who & when) _____

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Tele-Mental Health Consent

I consent to telehealth services for counseling with Garland Counseling Center.

I understand that counseling sessions will not be recorded and are confidential with the exception of abuse to children, elders and protected persons or suicidal/homicidal intent.

I agree to make every effort to meet in a private location without interruptions.

I understand that every effort is made to protect confidentiality, but that unauthorized persons may breach cyber-security measures.

I understand that sessions may be interrupted due to technical issues.

If this happens, I will re-start the call. If we are unable to resolve the connection problem, therapist will call to continue the session by alternative platform or phone or to re-schedule.

I understand that my therapist has a limited ability to respond to emergencies with telehealth. If I am unable to remain safe at this level of care, I will call 9-1-1 or go to my nearest emergency room so a professional can monitor me for safety.

I understand that my therapist may need to contact my emergency contact, listed below.

In case of emergency, my location is: _____

My emergency contact information is as follows:

Name: _____

Phone number: _____

Address: _____

_____

Client signature: _____ Date: _____

Therapist signature: _____ Date: _____

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3. You have the right to look at the health information we have about you, such as your medical chart, case file, and billing records. You can get a copy of these records, and we can charge you for it. Please talk to our compliance officer to arrange how to see your records.
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