

# **Client Demographic Information:**

Client's Name:		Date of Birth:	
Phone #:		Social Security #:	
Email address:	<del></del>	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:		#: <u> </u>	
Name:	Phone	#:	
If client is a minor, please complete parents/legal	guardians' i	nformation below:	
Parent/Guardian Name #1:			
Address:			
Parent/Guardian Name #2:			
Address:		_ Email:	
Referral source: How did you hear about us?			
I consent to financial, appointment and welfare co	mmunicatior	n from this office as follows:	
Yes/No Phone call			
Yes/No Phone text			
Yes/No Email			
Signature:		Date <mark>:</mark>	



### **Confidentiality and Counseling Agreement:**

<u>Confidentiality and access to records:</u> 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 subpoen a 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.

<u>What to expect:</u> 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.

<u>Complaints</u>: Complaints may be directed to the following:

CONSUMER COMPLAINT HOTLINE: 1-800-821-3205

Texas Behavioral Health Executive Council

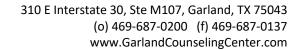
George HW Bush State Office Building – 1801 Congress Ave, Ste 7.300

Austin, TX 78701

I <u>consent</u> 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: \_\_\_\_\_

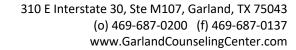
Counselor's name & signature: \_\_\_\_\_





# Consent to Use and Disclose Your Health Information

This form is an agreement between you,	
When we examine, evaluate, diagnose, treat, or refer you, we will be information" (PHI) about you. We need to use this information in our office provide this treatment to you. We may also share this information with on help others provide other treatment to you, or to carry out certain business.	ce to decide what treatment is best for you and to thers to arrange payment for your treatment, to
By signing this form, you are agreeing to let us use your PHI here a just above. Your signature below acknowledges that you have read or h explains in more detail what your rights are and how we can use and sh agreeing to our privacy practices, we cannot treat you, because we need you.	eard our Notice of Privacy Practices, which are your information. If you do not sign this form
In the future, we may change how we use and share your PHI, and Practices. If we do change it, you can get a copy from our compliance of 469-687-0200 and delenecounselor@gmail.com.	
After you have signed this consent, you have the right to revoke it I stop using or sharing your PHI, but if we have already used or shared so	
Signature of client or personal representative	e 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





### 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

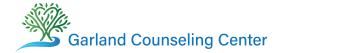
- 1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, rather than at work, to schedule or cancel an appointment. We will try our best to do as you ask.
- 2. You can ask us to limit what we tell 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.



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

### **Consent for Release of Information:**

+For the purpos emergency (E),			coordination of ins	urance/disab	ility benefits	(COB),
**Dates are typ	ically date of aa	mission through	h date of discharge,	unless other	wise specified	d.
Name	Relationship Family, friend	Phone #	Address (city)	Consent? Yes or No	+Purpose: COC, COB, E, Other	**Dates:
	Insurance Co.	Ph:	PO Box # City: State:		СОВ	
	Disability Co.	Ph:	Claim #:  Care mgr:		СОВ	
	PCP/Dr.	Ph:			COC	
	Psychiatrist	Ph:			COC	
	Specialist	Ph:			COC	
	Spouse/Partner					
l,			s name or Legal rep		•	
Delene Penix, LI	PC and/or Abiga		disclose records an to the above names			_
Such disclosure	shall include the	e complete reco	ord unless otherwise	e indicated.		
Initial:status and/or su			re may also include	any informat	ion related to	o AIDS/HIV
				D	ate:	
Client's date of	birth:		Client's S	ocial Security	#:	
Legal Represent	tative's signatur	e:		D	ate:	
Witness signatu	re:			D	ate:	



### **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 <b>pay</b> \$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





### 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 goals for counseling. (what do you want to be unferent when we mish:)
What are your personal strengths?



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# **Personal History**

Allergies & Rea	action:			
Medical condit	ions:			
Current medica	ations: (Attach list, if n	eeded)		
Name	Reason	Dose	Frequency	Take as directed?
Who is suppor	tive?			
Exercise: Yes/N	NoType of exercise?	Ho	w often?	How long?
Nutrition: Heal	lthy, Normal, Bingeing	, Purging, Laxative/[	oiuretic use, Over/Unde	er-eating, Eating Disorder
Sleep: # of hou	ırs daily =	Sleep problems: Ti	ouble falling/staying as	sleep, Naps, Nightmares
Hobbies:				
Legal issues: _				
Drug/Alcohol u	ıse:			
Nicotine/Tobacco use: Caffeine use:				
Past surgeries:				
Past hospitaliza	ations:			
, ,				
Trauma history	$\chi$ (circle all that apply):	Physical abuse	&/or Sexual abuse	
Witn	essing or Experiencing	g Murder/Suicide/Ra	pe/Life threatening acc	cident/Natural disaster
Your age at tim	ne of trauma:			
How did you k	now your abuser(s) ar	nd was it reported?:		





# **Family History**

, , ,	Nom, Dad, Step-mom, Step-dad, Brothers (#), Sisters (#), ther
Are your parents living?	Are your siblings living?
How would you describe your parents?	
If you have any siblings, what is your birth o	order?
Briefly describe any relationship issues with	nin the family:
Chronic, severe, or terminal illness: (who &	what)
Developmental, neurological, intellectual d	isorders: (who & what) (examples: autism, ADHD, Down's)
Mental Illness: (who & what)	
Chemical Dependency: (who)	
Suicide/Attempt: (who)	
Abandonment: (who & when)	



# **Garland Counseling Center**

#### 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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When we examine, evaluate, diagnose, treat, or refer you, we information" (PHI) about you. We need to use this information in our provide this treatment to you. We may also share this information winelp others provide other treatment to you, or to carry out certain but	office to decide what treatment is be ith others to arrange payment for you	st for you and to
By signing this form, you are agreeing to let us use your PHI houst above. Your signature below acknowledges that you have read explains in more detail what your rights are and how we can use an agreeing to our privacy practices, we cannot treat you, because we you.	or heard our Notice of Privacy Praction of the share your information. If you do not not the share your information.	ces, which ot sign this form
In the future, we may change how we use and share your PHI, Practices. If we do change it, you can get a copy from our compliand 169-687-0200 and delenecounselor@gmail.com.		
After you have signed this consent, you have the right to revok stop using or sharing your PHI, but if we have already used or share		
Signature of client or personal representa	ative	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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