New Client Information Sheet

Please complete **ALL** questions

PSY Family Services
301 W. Rosedale, Fort Worth, TX 76104

1. Client Demographics

Patient Name: Last:	First:	Middle:

Sex: ( )M ( )F	DOB:	Age:	School Grade:	Marital Status: ( )Single ( )Separated ( )Married ( )Divorced	Ethnic Origin: ( )Caucasian ( )African-Amer. ( )Amer. Indian ( )Hispanic ( )Asian

Address:	Apt. #:	City:	State/Zip:

Home Phone: ( )-	Social Security #:	Drivers License #:	State of License:

Employer Name:	Occupation:	Length of Employment:	Employer Phone Number: ( )-

Employer Address:	Suite #:	City:	State/Zip:

2. Emergency Contact

Emergency Contact:
Name:

Address:	Apt. #:	City:	State/Zip:

Home Phone: ( )-	Work Phone: ( )-	Relationship:

3. Referral Source

How were you referred to this office?

( )Insurance ( )Hospital ( )Mental Health Professional ( )Other:_____

4. Previous Counseling

Last 12 months: ( )Yes ( )No	When:	How Long:

Where:	Why:	If ended, why:

5. Health Insurance Information

Insurance Company:	Policy #:	Group Name:	Group #:

Insured's Full Name:	Sex: ( )M ( )F	Relationship:	DOB:

Employer Name:	Employer Phone Number: ( )-

Employer Address:	Suite #:	City:	State/Zip:

PSY Family Services

Assessment and Counseling Services
301 W. Rosedale, Fort Worth, TX 76104
(817) 338-4471

CLIENT INFORMATION AND CONSENT

Consent to Treatment
I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time. I understand that the session may be audio or video taped for educational purposes.

Appointments
Appointments are made by calling (817)338-4471. Please call to cancel or reschedule at least 24 hours in advance, or you may be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments.

Number of Visits
The number of sessions needed depends on many factors and will be discussed by the therapist.

Length of Visits
Therapy sessions are approximately 45-50 minutes in length. The charge for individual and family sessions is $75.00 per visit, unless there is an agreed-upon rate with your insurance. Different co-payments are required by various group coverage plans.

Confidentiality
Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the managed care company and/or insurance carrier responsible or providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

Duty to Warn

In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel.

NAME **TELEPHONE NUMBER**

_____

_____

_____

Risks of Therapy

Therapy is the Greek word for change. You may learn things about yourself that you don't like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein.

_____ _____

Client Date

_____ _____

Parent/Guardian Date

(if client is under 18 years of age)

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RELEASE OF INFORMATION

CLIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

By signing below, I hereby authorize PSY Family Services, to Release and to obtain information with respect to any physical, psychiatric or drug/alcohol related condition obtained during the course of diagnosis and/or treatment to/from the individual(s) or healthcare providers below. The type of information authorized for disclosures includes, but may not be limited to notification of admission/discharge, Psychiatric Evaluation, reports of Testing, discharge planning and summary, progress and treatment reports, physical exam, assessments, treatment content, treatment progress, payment records, social history, and any statements made by me to PSY Family Services. The purpose of this disclosure is to identify persons supporting and using services, to aid in diagnosis, continuing care, and treatment.

Mental Health Professional (name, address, phone)

_____

Primary Care Physician (name, address, phone)

_____

Psychiatrist (name, address, phone)

_____

Family / Parent / Guardian (name, address, phone)

_____

_____

_____

Insurance (name, address, phone)

_____

Other (name, address, phone)

_____

_____

I have been advised that I may revoke this release of information at any time, except to the extent that information has already been released.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian *(if client is a minor under 18 years of age)* Date

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Health Insurance Portability and Accountability Act (HIPAA) Notice

This notice describes how psychotherapy and medical information about you may be used and disclosed and how you can get access to the information, Please review it carefully. This information is required under the Health Insurance Portability and Accountability Act (HIPAA) passed by Congress in 1996.

I. Uses and Disclosures for Treatment, Payment and Health Care Operations
Your protected health information (PHI) may be used and/or disclosed for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- PHI refers to information in your health record that could identify you
- Treatment, Payment and Health Care Operations
  - Treatment is when your health care and other services related to your health care are provided or managed. An example of this is consultation with another health care provider, such as your family physician or another mental health professional
  - Payment is being reimbursed for your health care, Examples of payment are when your PHI is disclosed to your health insurance to obtain reimbursement for your health care or to determine eligibility or coverage
  - Health Care Operations are activities that relate to the performance and operation of this practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination
- Use applies only to activities within the office, clinic, practice group, etc , such as sharing, employing, applying, utilizing, and examining information that identifies you
- Disclosure applies to activities outside of the office, clinic, practice group, etc , such as sending, transferring, or providing access to information about you to other parties

II. Uses and Disclosures Requiring Authorization
PHI may be used or disclosed for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An authorization is written permission above and beyond course that permits only specific disclosures. In those instances when asked for information for purposes outside of treatment, payment, and health care operations, authorization will be obtained from you before releasing this information Authorization will also need to be obtained before releasing your psychotherapy notes. Psychotherapy notes are notes created during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.
You may revoke all authorizations of PHI or psychotherapy notes at any time, provided each revocation is in writing You may not revoke an authorization to the extent that that authorization has been relied on or if the authorization was obtained as a condition of gaining insurance coverage and the law provides the insurer the right to contest this right under that policy.

III. Uses and Disclosures with Neither Consent or Authorization
PHI may be used or disclosed without your consent or authorization in the following circumstances:

- Child Abuse: if there is cause to believe that a child has been or may be abused, neglected, or sexually abused, a report of such must be made 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
- Adult and Domestic Abuse: If there is cause to believe that any elderly or disabled person is in a state of abuse, neglect, or exploitation, it must immediately be reported to the Department of Family and Protective Services
- Health Oversight: If a complaint is filed against treatment staff with any of the applicable State Licensing Boards they have the authority to subpoena confidential mental health information relevant to that complaint

- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and the information would not be released without written authorization from you or your personal or legally appointed representatives, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case
- Serious Threat to Health or Safety: If it is determined that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, relevant confidential mental health information may be disclosed to medical or law enforcement personnel
- Workers Compensation: If you file a worker's compensation claim, records may be disclosed relating to your diagnosis and treatment to your employer's insurance carrier

IV Patient's Rights and Psychotherapist's Duties Patient's Rights:

- Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of PHI about you. However, agreement to a restriction you request is not required
- Right to Receive Confidential Communications by Alternative Means and Alternative Locations-You have the right to request and receive confidential communication of PHI by alternative means at alternative locations For example, you may not want a family member to know that you are being seen. Upon your request, bills or other materials will be sent to another address
- Right to Inspect and Copy-You have the right to inspect and/or obtain a copy of your PHI and psychotherapy notes in your mental health and billing record. Access to your PHI may be denied under certain circumstances, but in some cases you may have this decision reviewed. On your request, the details of the request and denial process will be discussed with you.
- Right to Amend-You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. On your request, the details of the amendment process will be discussed with you.
- Right to an Accounting-You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice) On your request, the details of this accounting process will be discussed with you
- Right to Paper Copy-You have the right to obtain a paper copy of the notice upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:

- Treatment staff is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
- Treatment staff reserves the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, treatment staff are required to abide by the terms currently in effect
- If the policies and procedures are revised, a copy will be available at our office.

V Questions and Complaints

If you have questions about this notice, disagree with a decision made about access to your records, or have other concerns about your privacy rights, you may contact treatment staff. You may send a written complaint to the Secretary of the U S. Department of Health and Human Services. You have specific rights under the Privacy Rule. Retaliation against you for exercising your right to file a complaint will not be made.

VI Effective Date of Privacy Policy

This notice will go into effect on October 1, 2010.

I have read and understand the above HIPAA notice.

_____ _____

Signature Date