Therapist: Susan Gonzales LPC-S, LMFT **COUPLE**

REGISTRATION INFORMATION

CONFIDENTIAL

Today's Date:_____

Your Name: _____

Gender: ☐ Male ☐ Female Birthdate: _____Age:_____

Preferred Phone #: _____Is it ok to leave voicemails? ☐ Yes ☐ No

Preferred Method of Communication: ☐ Email ☐ Phone ☐ Text

Home Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____Employer: _____

Relationship Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed

☐ Separated

Emergency Contact: _____ Phone #: _____

Physician/Physiatrist name: _____ Phone #: _____

Please list any medications that you are currently taking (name, dosage, prescribing doctor):

_____

_____

Name of Partner/Spouse: _____

Gender: ☐ Male ☐ Female Birthdate: _____Age:_____

Preferred Phone #: _____Is it ok to leave voicemails? ☐ Yes ☐ No

Preferred Method of Communication: ☐ Email ☐ Phone ☐ Text

Home Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____Employer: _____

Relationship Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed

☐ Separated

Emergency Contact: _____ Phone #: _____

Physician/Physiatrist name: _____ Phone #: _____

Please list any medications that you are currently taking (name, dosage, prescribing doctor):

_____

_____

Client referred By…..

☐ Online Search

☐ Psychology Today

☐ Insurance

☐ Professional referral:_____Permission to thank this referral? ☐ Yes ☐

No

☐ Personal referral: _____Permission to thank this referral? ☐ Yes ☐

No

Have you had any prior couples counseling? ☐ Yes ☐ No

If answered yes above, please describe when, duration, therapist name and what was helpful/unhelpful:

_____

_____

_____

What brings you into counseling this time? _____

_____

Therapist: Susan Gonzales LPC-S, LMFT **COUPLE**

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

I. Uses and Discloses for Treatment, Payment, and Health Care Operations.

Your therapist may use or disclose your protected health information (PHI), 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 therapist provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when consulting with another health care provider such as your family physician, social worker, therapist, or psychologist, or psychiatrist.
    - *Payment* is when your therapist obtains reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer 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 my practice. We may disclose, as needed, your PHI in order to support my business activities, including, but not limited to, quality assessment activities, employee review activities, licensing and conducting or arranging for other business activities. Furthermore, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes, PHI will be disclosed only with your authorization.
- "Use" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes*" are notes I have made about our

conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such 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 (l) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse**: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must by law make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas youth commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse**: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Deceased Patients**: I may disclose PHI regarding deceased patients as mandated by state law or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin, PHI persons that have been deceased for more than fifty (50) years is not protected under HIPAA.
- **Abuse by a Therapist**: If I have cause to believe that you have been the victim of sexual exploitation by a mental health professional during the course of treatment, I will report this to the appropriate State Examining Board.
- **Medical Emergencies**: I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. I will try to provide you with a copy of the notice as soon as reasonably practicable after the resolution of the emergency.
- **Family Involvement in Care**: I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.
- **Health oversight**: If a complaint is filed against me with the appropriate State Board: The Texas State Board of Examiners of Psychologists, The Texas Board of Medical Examiners, The Texas State Board of Social Work Examiners, the Texas State Board of Marriage and Family Therapists, or The Licensed Professional Counselor Board – they have the authority to subpoena confidential mental health information from me 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 I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The 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 of this is the case.
- **Serious Threat to Health or Safety**: If I determine 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, I may disclose relevant confidential mental health information to medi-

cal or law enforcement personnel.

- **Worker's Compensation**: If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Therapist Duties

Patient's Rights:

- Right to Request Restrictions -You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternate Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternate locations. (For example, you may not want a family member to know that you are in counseling. Upon request, I will send information to another address.)
- Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment Process.
- 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, I will discuss with you the details of the accounting process.
- Right to a Paper Copy - You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you a revised copy at your next visit or by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy right, you make talk with me. If you believe that your privacy right have been violated and wish to file a complaint with us, you may send your written complaint to the address provided on our letterhead. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific right under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date. Restrictions and Changes to Privacy Policy

This notice will go into effect on July 25, 2013. I reserve the right to change the terms of this notice and to make the new notice provisions for all PHI that I maintain. I will provide you with a revised notice at your next visit or by mail.

Therapist: Susan Gonzales LPC-S, LMFT **COUPLE**

ACKNOWLEDGEMENT

I have reviewed and received a copy of the Notice of Policies and Practices to Protect the Privacy of my health information, which explains how my health information will be used and disclosed.

_____
Client Signature

_____
Printed Name

_____
Client Signature

_____
Printed Name

_____
Date

Therapist: Susan Gonzales LPC-S, LMFT **COUPLE**

STATEMENT OF UNDERSTANDING

Consent for Care:
I give full consent for the completion of my evaluation and provision of treatment as necessary, by the above named therapist, until otherwise notified. I understand that no promises have been made to me as to the result of treatment or procedures provided by this therapist. If I have any questions about the following information or about anything related to my therapy, I will discuss this with the therapist.

Confidentiality:
You have the right to confidentiality in your therapy. Information concerning your therapy will not be disclosed without your prior written permission except for the following legal exceptions:

1. Life or safety of you or someone else is seriously threatened.
2. There is good reason to believe that you are abusing or neglecting a child or vulnerable adult or if you give me information about someone else who is doing this, child/adult protective services and/or the appropriate law enforcement agency must be notified.
3. Court ordered.
4. An insurance benefit is filed and the claims payer requires information, i.e. diagnosis, types of treatment, dates, etc.
5. Parents or legal guardians of minors are legally privy to information disclosed during treatment. The therapist will discuss and clarify issues of privileged information regarding the child's treatment.

Emergencies/Telephone Counseling and email:
Emailing is an appropriate form of communication, but can only be utilized for correspondence related to initial paperwork, scheduling of appointments or making payment arrangements. All other matters will be discussed in session or over the phone. Please note that there is no guarantee in ensuring the confidentiality of emails. I will return your phone call within 24-48 hours. If there is a psychiatric emergency, or if life or safety is threatened, please call 911.

Scheduling of appointments:
Please conscientiously keep all scheduled appointments. If it is necessary to cancel an appointment, you must give at least 24 hour notice. **You will be charged a $45 fee for missed appointments or appointments canceled without 24 hours advanced notice.** The credit card on file will be charged the $45 late cancellation fee at the time of the missed appointment.

Fee policy:
All charges are your responsibility and are due at the time of service. Any returned checks are subject to a $25 charge. Should your account be referred for collection, you agree to pay 6% interest plus a $25 collection fee and reasonable attorney fees and/or court costs.

Fees for services:

- Initial Consultation (Individual) (60 min.) = $120
- Individual psychotherapy (55 min) = $100
- Individual psychotherapy (90 min) = $150
- Initial consultation (Marital/Family) (60 min) = $140
- Marital/Family psychotherapy (55 min) = $120
- Marital/Family psychotherapy (90 min) = $180
- Emergency calls (or scheduled phone calls) = $30/15 min. or $50/30 min.
- Release of records = $25 to $50
- Deposition/Court Appearance = $250/hour
- Court Appearance due to subpoena = $250/hour
- Telephone consultation w/ attorney = $30/15 min.

I work with a group of independent mental health professionals. We are a group of independently, practicing professionals who share certain expenses and office space. While we share expenses and office space, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no one can have access to them without your specific, written permission.

I UNDERSTAND AND AGREE TO THE ABOVE TERMS.

_____ _____

Client Signature Date

_____

Printed Name

_____ _____

Client Signature Date

_____

Printed Name

Therapist: Susan Gonzales LPC-S, LMFT **COUPLE**

Credit Card Authorization Form

Date: _____

Client Name _____

I am providing the following credit card information for Ms. Susan Gonzales to keep on file in the event that I do not keep an appointment or I cancel an appointment without the required advance notice (with full details of relevant office policies provided to me on separate forms).

I authorize Susan Gonzales to charge my credit card the full specified amount for the missed appointment.

VISA Mastercard American Express (circle one)

Card Number: _____

Expiration Date: _____

CVC code: _____

Name on Card: _____

Signature: _____