Positive Influences

Informed Consent

It is our aspiration that each person will grow and learn from the therapeutic experience. With this in mind, please be aware that you are partly responsible for the outcome of your counseling experience. At the outset of counseling, we - you and I - will determine what it is you would like to address. Please be aware that counseling may open levels of awareness that could cause pain and anxiety. We can address these issues as they arise and assist you with coping technique to effectively process your experience.

Please remember the following:
The length of therapy depends upon the issues presented and the progress being made. Both you and I will determine when therapy should terminate as this is an important aspect of therapy. It will be openly explored by you and me.

Should we discover that I as a therapist am not beneficial to your therapeutic process, a referral can be made so that you may continue exploring the concerns which initially brought you to therapy. In my absence, I will designate a competent therapist to handle my appointments and emergencies. You will be notified of any periods in which I will not be readily available.

Confidentiality
Your sessions are strictly confidential. However, there are exceptions to the rule of confidentiality

- Situations in which you impose a danger to yourself or others
- Situations in which a referring source has been permitted to receive information or other arrangements have been made.
- Situations in which you request your records are released to a third party
- Situations in which a court orders me to make the records available
- Situations in which you inform me that a child is being abused

You may have access to your files. However, I recommend not accessing your files until therapy is terminated. Should you decide to read your files, I will be present to address any questions which may arise as a result.

You are expected to pay at the end of each session unless other arrangements have been made with the accounting staff. Therapy will not be prolonged for the single purpose of financial need. As stated before, you and I will discuss when to terminate therapy. No unexpected costs will be placed upon you. All costs will be explained to you in detail before occurring. If you are using insurance, please notify us of any changes. Again, you are required to pay at the end of each therapy session.

Regarding your diagnosis:
Your insurance company will require a diagnosis as well as most other agencies. I encourage you to act on the basis of what you believe is best for you and move beyond the labels. There are alternatives to traditional therapy which I can recommend should you decide to try an alternative method of working through the issues presented. In any type of therapy, there are benefits as well as risks. No promises can be made of specific outcomes. However, be assured that I will assist you in processing the issues you state you would like to explore. Again, full participation is required for gainful insight.

Questions are encouraged throughout the therapeutic process. You are the major part of this therapeutic experience and it is recommended that you fully access the services being offered. Hence, this informed consent document so that you may be totally aware of the legal and ethical responsibilities of me as your counselor.

I,__________________________, having discussed the above document with my counselor,

- Affirm that I understood the above document and am able to inquire of any issues pertinent to my therapeutic process.
- Have the right to withdraw from treatment at any time. (It is recommended I speak with my counselor prior to making my final decision.)
- Am aware of the benefits and the risks associated with counseling.
- Am aware of the type of treatment being offered and have been advised of alternatives to this method of therapy.
- Am aware of the issues of confidentiality and the limitations.
- I have received a copy of HIPAA information.

____

(Client's signature and date)

Positive Influences

REGISTRATION

(Please print and complete all sections)

Date ______________________ Home phone number ______________

Client Name Last ______ First ______ MI ____ Race (optional) ______

Responsible Party (if a minor) ______________________________

Street Address ______________________________

Street name and number Apt. # City State Zip

Sex ☐M ☐F Age ____ Birth date ______ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Client employed by: ______________________ Occupation ______________

Business address: ______________________ Business Phone ______________

Spouse (or Responsible Party) ______________________ Birth date ______________

Business Name & Address ______________________________

Business phone ______________ Occupation ______________

Who is responsible for this account ______________ Relationship to client ______________

Client's social security # ______________ Spouse (Responsible Party) social security # ______________

Do you have Medical insurance ☐No ☐Yes If yes, Name of Primary Insurer ______________

Contract # ____________ Group # ____________ Subscriber # ____________

Name of Secondary Insurer (if any) ______________________________

Contract # ____________ Group # ____________ Subscriber # ____________

☐ Medicare ☐ Medicaid Claim ID # ______________

In case of emergency, who should be notified(relationship)? ______________ Phone ______________

How did you learn of our practice? ______________________________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ______________________(Name of Insurance Company) and assign directly to ______________________ all counseling benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian______________________________ Date ______________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on behalf to ______________________ for any services furnished by that psychotherapist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Beneficiary______________________________ Date______________

Clinical Assessment

Client Name ______________________ Emergency Contact & phone ______________________

Adults

Marital Status

☐ Single ☐ Divorced ☐ Married

☐ Separated ☐ Widowed ☐ Living Together

Spouse/Partner Name: ______________________

Is it okay to contact you at work in the event that there is a change of your appointment or other matters concerning your treatment?___

Is it okay to contact you at home in the event that there is a change of your appointment or other matters concerning your treatment?___

Name of Children *If client is a child; name siblings*	Date of Birth	Lives with you	
		☐Yes	☐ No
		☐Yes	☐ No
		☐Yes	☐ No
		☐Yes	☐ No
		☐Yes	☐ No

Children and Adolescents

Name of school & city ______________________ Grade ________

Briefly describe reports received from school regarding behavior and academic achievement ______________________

____

Has youth had any problems with the law? Please describe, if so ______________________

____

Adults, Children and Adolescents

Briefly describe nature of your problems:______________________

____

What counseling or treatment have you had before? ______________________

____

Why did you decide to seek help now?______________________

____

What other ways have you tried to handle this problems?______________________

____

Is anyone using or having problems with drugs or alcohol in the family? ______________________

____

CLINICAL ASSESSMENT - PART II

Client Name ______________________________

Adults; Work problems/Stressors: ______________________________

Youth; School problems/Stressors: ______________________________

RELEVANT SOCIAL AND MEDICAL HISTORY

Please, elaborate on any questions with a yes answer.

Question	Yes	No	Elaboration
Family history of mental illness	☐ Yes	☐ No	
Significant family background issues	☐ Yes	☐ No	
Sexual abuse	☐ Yes	☐ No	
Physical abuse/domestic violence	☐ Yes	☐ No	
Other losses/traumas	☐ Yes	☐ No	
Lack of support systems	☐ Yes	☐ No	
Are you currently taking any medication?	☐ Yes	☐ No	
Are you allergic to anything?	☐ Yes	☐ No	
Are you under the care of a psychiatrist or physician?	☐ Yes	☐ No	
Are you or have you ever been suicidal?	☐ Yes	☐ No	

CLINICAL NOTES

HISTORY OF PRESENTING PROBLEMS

____

____

____

____

____

____

____

____

Clinician Signature ______________________________ Date ____________________

Positive Influences

NOTIFICATION OF APPOINTMENT POLICY

YOUR APPOINTMENT

Your time with the counselor is very important. Please arrive to your appointment timely so as to maximize the quality of service received. Your sessions will last approximately 50 minutes weekly unless you and your counselor decide alternate arrangements are required.

CANCELLATION OF APPOINTMENT

Please contact the office at least **24 hours** ahead if you are unable to keep your scheduled appointment.

In the case of an emergency, please contact the office as soon as possible.

It is the policy of our office to proceed with billing if the appointment is not properly canceled. The insurance companies generally do not incur these charges. Therefore, the client is solely responsible for reimbursing these fees to the counseling center.

If you miss an appointment, you are required to reschedule the appointment. If you do not call to reschedule, **the appointment time is not guaranteed for the following week**. Please, always call to avoid any confusion when you are unable to keep your appointment.

IT IS VERY IMPORTANT THAT YOU BE RESPONSIBLE IN CANCELING YOUR APPOINTMENT.

IF YOU MISS MORE THAN 3 APPOINTMENTS FOR ANY REASON, YOUR SERVICES WILL BE DISCONTINUED WITHOUT FURTHER NOTIFICATION.

PAYMENT OF SERVICES

All fees are due at the beginning of the session.

Insurance co-payments are to be made to the counselor at the beginning of the session.

Other methods of payment are to be arranged through the funding source. If you have not already done so, please confirm with your funding source that you are eligible to receive assistance for counseling services.

If you have any questions or concerns, please speak with your counselor.

______________________________ ______________

Client Signature Date

Positive Influences

Patient's Acknowledgement of
Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of Positive Influences Notice of Privacy Practices."

We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

Signature: ____

Printed Name: ____

Date: ______________________

Positive Influences

"Notice of Privacy Practices"
THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS
AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED,
AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. **However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship** (by signing the attached general consent form), **or through your written authorization at the time the need for disclosure arises.** You may revoke your permission, in writing, at any time, by contacting me.

II. "Limits of Confidentiality"
Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· **Emergency** If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

· **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Texas law to report the matter immediately to the Texas Department of Social Services.

· **Adult Abuse Reporting:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Texas law to immediately make a report and provide relevant information to the Texas Department of Welfare or Social Services.

· **Health Oversight:** Texas law requires clinicians report misconduct by a health care provider of their own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. [For Counselors: Texas law requires that licensed counselors report misconduct by any mental health care provider.] By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. Texas Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.

· **Court Proceedings:** If you are involved in a court preceding 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 unless you provide written authorization or a judge issues a court order.

· **Serious Threat to Health or Safety:** Under Texas law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.

· **Workers Compensation:** If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

· **Records of Minors:** Texas has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Patient's Rights and Provider's Duties:

· **Right to Request Restrictions-**You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

· **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations --** You have the right to request and receive confidential communications of PHI by

alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· **Right to an Accounting of Disclosures -** 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 written request, I will discuss with you the details of the accounting process

· **Right to Inspect and Copy** - In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

· **Right to Amend** - If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· **Right to a copy of this notice -** You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date . A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to the main office of Positive Influences with the following information:

Positive Influences
ATTN: Stacia' Alexander, Executive Director
8828 N. Stemmons Frwy. Suite 225
Dallas, TX 75247

You may also send a written complaint to the U.S. Department of Health and Human Services.