

FAMILY COUNSELING CENTER ASSN.



CLIENT NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ SS#: _____

PHONE NUMBER: HOME: _____ CELL: _____

PERSONAL DATA

DATE TODAY: _____ REFERRED BY: _____

INDIVIDUAL DATA

SEX: _____ DATE OF BIRTH: ___/___/___ AGE: _____ HEIGHT: _____ WEIGHT: _____

EDUCATION COMPLETED (GRADES, DEGREES OR COURSES) _____

YOUR LIFE: HAPPY: _____ AVERAGE: _____ UNHAPPY: _____ VERY UNHAPPY: _____

OCCUPATIONAL DATA

PLACE OF EMPLOYMENT: _____ PHONE: _____

PREVIOUS EMPLOYMENT: _____ PHONE: _____

ANNUAL INCOME BEFORE DEDUCTIONS: YOURS: _____ MATE'S: _____

PHYSICAL HEALTH DATA

VERY GOOD: _____ GOOD: _____ AVERAGE: _____ POOR: _____

LIST PRESENT ILLNESSES, INCLUDING ALLERGIES: _____

WHEN WAS YOUR LAST MEDICAL CHECK UP? (DATE): _____

FINDINGS: _____

LIST OR DESCRIBE PURPOSE(S) OF MEDICATION OF ANY KIND NOW BEING
TAKEN: _____

YOUR PHYSICIAN: _____

ADDRESS: _____

Emergency contact person: Name: _____ ph# _____

EMOTIONAL HEALTH DATA

HAVE YOU EVER HAD SERIOUS MENTAL DISTURBANCE OR A NERVOUS BREAKDOWN? _____ IF SO, WHEN? _____

HAVE YOU HAD THERAPY BEFORE? _____ YES _____ NO _____ WHEN? _____ WITH WHOM? _____

HAVE YOU EVER WITNESSED OR BEEN EXPOSED TO A TRAUMATIC EVENT? _____

(This includes experiencing combat, witnessing an accident or death, being involved in a natural disasters--fire, flood, tornado, hurricane--or have you been the victim of abuse, sexual or otherwise, in childhood or as an adult.)

MARITAL AND FAMILY STATUS

MARRIED _____ SINGLE _____ GOING STEADY _____ ENGAGED _____

WIDOWED _____ IF SO, WHEN? ____/____/____

DIVORCED _____ IF SO, WHEN? ____/____/____

MARRIED WHEN? ____/____/____

HOW LONG DATING MATE? _____

SPOUSE'S NAME _____

MATE'S AGE _____ MATE'S EDUCATION _____ MATE'S RELIGION _____

SEPARATED? _____ IF SO, WHEN? ____/____/____

PREVIOUS MARRIAGES:

HOW MANY? _____ HOW TERMINATED? _____

CHILDREN: AGE: DOB: COMMENTS:

ANY LEGAL ACTION PENDING? _____ YES, _____ NO

IF YES, DESCRIBE: _____

RESPONSIBLE PARTY INFORMATION:

RELATIONSHIP TO PATIENT: _____

RESPONSIBLE PARTY NAME: _____

ADDRESS: _____

CITY, STATE & ZIP: _____

HOME PHONE: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

OCCUPATIONAL INFORMATION:

EMPLOYER: _____

EMPLOYER ADDRESS: _____

WORK PHONE: _____

ANNUAL INCOME BEFORE DEDUCTION: _____

Family Counseling Center Association
2401 OAKLAND BLVD.
FORT WORTH, TEXAS 76103

STATEMENT OF INFORMED CONSENT

I, the undersigned, do hereby acknowledge, understand and consent to the following for psychotherapy and/or counseling service for myself and/or for _____ a minor of whom I am the parent or legal guardian.

- 1.) The psychotherapy and/or counseling will be conducted by a qualified psychotherapist/counselor.
- 2.) I understand according to the professional licensing law and professional ethics, these professional counselors are qualified to help me be released to experience further interpersonal and intrapersonal development.
- 3.) Specific objectives and methods are to be agreed upon in consultation with the therapist. I understand that a non-physician therapist will not prescribe medicine.
- 4.) The therapist is a consultant and resource professional. His/Her suggestions may be freely accepted or rejected by the client. Therefore, decisions made during and after therapy are the responsibility of the client.
- 5.) Consultations, test results and disclosures between the counselor and the client will be held in confidence within the restrictions of Texas state law. These exceptions to confidentiality include cases in which: (1) illegal activity is occurring (such as physical or sexual abuse); (2) the purpose of counseling is to obtain a court evaluation; or (3) legal action regarding the therapy itself (such as a malpractice suit) is in progress.
The counselors are ethically and legally responsible to protect and maintain the counseling relationship while not in conflict with the basic laws of society.
- 6.) I affirm that I have read all the conditions above and that they have been fully explained to my satisfaction. I understand and agree to them freely and without reservation.

DATE _____

SIGNED _____ WITNESS _____

CONSUMER COMPLAINT HOTLINE 1-800-942-5540

LATE CANCELLATION/ NO SHOW POLICY

Full fee will be charged for all sessions where you no show or late cancelled with less than twenty-four (24) hour notice given. If an insurance patient, you will be responsible for full fee as we can not bill insurance company when you do not show.

Name

Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then your are bound to abide by such restriction.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____

Initials: _____

Reason: _____

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (“HIPPA”) is a federal program that requires that all medical records and individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPPA” provides penalties for covered entities that misuse personal health information.

As required by “HIPPA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not

required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20__ and we are required to abide by the terms of The Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA

Or to file a complaint:

The US Department of Health & Human Service

Office of Civil Rights

200 Independence Avenue, S. W.

Washington, D.C. 20201

(202)619-0257

Toll free: 1-877-696-6775