

Woodlands Family Institute, P.C.

PERSONAL DATA RECORD

Client's Name: _____ Date of Birth: _____

Parent's Name (If client is a minor): _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other: _____

SSN: _____ TXDL: _____

Employer/School: _____

Referred to our office by: _____

May we send a thank you to the person who referred you? (circle one) Yes No

May we mention your name in that thank you? (circle one) Yes No

EMERGENCY CONTACT

Name: _____ Relationship to client: _____

Address/Phone: _____

CONSENT FOR TREATMENT

Client's Name: _____ Date of Birth: _____

I give full consent for **myself, my child/adolescent or dependent due to legal guardianship** to receive outpatient mental health services until I notify WFI of any changes or until it is determined the treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for the individual stated above and that no additional person is required to authorize treatment.

Authorized Signature Date

AUTOMATIC PAYMENT

If you would like for us to automatically charge your credit/debit card for your fee, please provide the information below:

MC/VISA No. _____ Exp. Date _____

Name as listed on Card _____

Signature of Authorized User _____

FINANCIALLY RESPONSIBILITY

Name of person(s) financially responsible for this account: _____

Address: _____

Signature: _____

Relationship to client: _____

Office Policies
Leslie Alexander, LPC-I

Payment: Payment is expected at the time services are rendered unless other arrangements have been made. Please notify me if any problem arises during the course of your therapy regarding your ability to make timely payments. Follow up appointments will not be honored if an account has an outstanding balance.

***If an outstanding balance accrues, you will be billed on the first of the month and assessed a 2% finance charge, compounded monthly. There is a \$10.00 rebilling fee for every statement sent out after the first billing. There is also a \$25.00 fee for each check returned for insufficient funds. After 90 days with no payments or effort to arrange payment, accounts will be turned over to a collection agency which will impact your credit rating.

Standard Rates: Fee for sessions is \$100.00 per 50 minute session or prorated accordingly. Charges for other professional services are prorated on the basis of \$100.00 per hour. These services include, but are not limited to, phone calls, insurance reports, third-party consultations, and correspondence. Off-site consultation is charged at the rate of \$100.00 per hour, "portal to portal", that is, for the time I am out of the office on your behalf.

****Please be advised that I do not provide consultation, evaluation or legal expert testimony in child custody, child visitation or molestation cases. Similarly, I do not consider my practice to include expert testimonials. However, should my opinion be ordered, fees will be charged at the rate of \$500.00 per hour, portal to portal. This fee will apply as well to depositions or interrogatories. All fees of this nature are payable in advance.*

Cancellations: The scheduling of an appointment involves the reservation of time specifically for you. Therefore, 24 hours cancellation notice is required in order for you to avoid being charged in full for the missed session.

Please note that insurance companies do not reimburse for missed appointments.

Emergencies: If a **TRUE** emergency arises after hours, please contact our answering services at 713-866-4494, inform the operator that you have an emergency and request that your therapist be contacted immediately.

Insurance: Clients who carry insurance should remember that professional services are rendered and charged to the client, not the insurance company. We will provide you with a receipt, which you can submit to your insurance company for reimbursement. If arrangements have been made, we will submit claims to your primary carrier only, on your behalf. Unless prior arrangements have been made the entire fee for service remains the responsibility of the client, including any portion not reimbursed by your insurance carrier. Woodlands Family Institute does not file out-of-network insurance claims.

****Please be aware that Third-party payers require the provision of a diagnosis and supporting clinical data. We have no control over the confidentiality procedure of third parties once clinical information leaves this office. In all likelihood, a computer record will be generated.*

Children: Unless children are seen in the context of treatment we request that you make alternative childcare arrangements during your sessions so that our full attention can be devoted to your priorities.

Cell Phones: We respectfully request that your cell phone be turned off during your session.

Confidentiality: The law protects the privacy of all communications between clients and counselors.

Office Policies
Leslie Alexander, LPC-I

In most situations we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by federal and state laws. There are other situations which require only that you provide written, advanced consent. Your signature on our **Acknowledgement Form** provides consent for those activities as follows:

We practice with other mental health professionals and utilize administrative staff. In most cases, some protected information must be shared with these individuals for both clinical and administrative purposes such as scheduling, billing and quality assurance. All administrative staff members have been trained on how to protect your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

Occasionally, it is helpful to consult other health and mental health professionals about a client. During a consultation, every effort is made to avoid revealing a client's identity. Any other professionals consulted are also legally bound to keep the information discussed confidential. These consultations are very common and routine and may not necessarily be mentioned in our sessions unless it seems important to our work together. If you would prefer to handle this differently please let me know.

We also have contracts with some business services, such as answering service, electronic claims processing services and managed care organizations. As required by federal law, we have formal business associate contracts with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. Details of these contracts are available upon request.

All information disclosed within sessions is confidential with the following exceptions:

- You direct me to disclose information to someone else
- If you are determined to be in imminent danger of harming yourself or someone else
- I am ordered by a court or regulatory body to disclose information
- You disclose abuse or neglect of children, the elderly, or disabled persons
- In the instance of reasonable suspicion of child or elder abuse
- The need to release information to other professionals involved in your treatment
- In proceedings in which a claim is made about one's physical, emotional, or mental condition
- When disclosure is relevant in any suit affecting the parent-child relationship. This includes divorce and child custody deliberations
- In legal or regulatory actions against a professional
- Where otherwise legally required
- If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to other parties
- If you disclose sexual misconduct by a therapist
- To individuals, corporations or governmental agencies involved in paying or collecting fees for services (this includes insurance companies). *Please be advised that insurance reimbursement usually requires background information, including substance abuse, diagnostic criteria and treatment plan form completion. In addition, please note that most applications for health insurance include a release of information for medical records (this would include therapy/counseling records).*

Having read the policies described above, I agree to all professional policies, agree to meet all financial obligations, and agree that this contract replaces any earlier contracts. Additionally, I understand that there can be no absolute guarantee of cure in the practice of counseling.

Client or Parent's/Guardian's Signature

Date

Woodlands Family Institute, P.C.

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 IT CAREFULLY.

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

Woodlands Family Institute (WFI) may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *general 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 we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a colleague.
Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we 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. 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 WFI such as utilizing information that identifies you.
- “*Disclosure*” applies to activities outside of WFI, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We 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 we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. “*Psychotherapy notes*” are notes we have made about our conversation regarding a private, group, joint, or family counseling session. 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 (1) we 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

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

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must 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.
- **Abuse of the Elderly and Disabled:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a therapist:** If you report to us any situation that constitutes sexual misconduct by a current or former therapist, then we are required to inform the licensing authority of the offending therapist.
- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, 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 we 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 if this is the case.
- **Serious Threat to Health or Safety:** If we 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, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and Our Professional Duties

Client'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, we are not required to agree to a restriction you request.
- *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 seeking our services. Upon your request, we will send bills or other correspondence 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. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we 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. We may deny your request. On your request, we 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, we 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 the notice from me upon request, even if you have agreed to receive the notice electronically.

Our Professional Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a current copy in our offices. A current copy will always be available on our web site and you may request a personal copy.

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 rights, you may contact Mary Piehl, Office Manager, or your therapist at (281) 363-4220.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Mary Piehl or your therapist at: 1610 Woodstead Ct., Suite 420, The Woodlands, TX 77380.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights 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 3/28/2005. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in our lobby and on our web site. You may request a personal copy at any time.

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Please indicate below how we may contact you and whether we can leave a message:

- Home Phone May we leave a message (Circle One)? Yes No
- Work Phone May we leave a message (Circle One)? Yes No
- Cell Phone May we leave a message (Circle One)? Yes No
- Unencrypted (normal) email (address): _____

If you would like us to use an address other than your home address for billing and other correspondence, please provide an alternative address below.

Other (Specify) _____

You may change the above instructions at any time by requesting another one of these forms or otherwise instructing us in writing.

ACKNOWLEDGEMENT

I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information and the Office Information and Office Policies.**

I understand and accept those policies and practices. WFI is hereby granted consent to contact me as specified above and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

Client or Authorized Representative Signature

Date

Refuse to Sign

Unable to Sign (specify reason) _____

Signature of Person Documenting Refusal or Inability to Sign

Date

Woodlands Family Institute, P.C.
Leslie Alexander, LPC-I

PSYCHOSOCIAL HISTORY

Client name _____ **Client Age** _____

Parent/Guardian name _____

Presenting Problems (Check all that apply):

Adjustment Issues		Unstable mood	
Depression		Grief/loss	
Suicidal/Homicidal gesture, attempt, or ideation		Substance abuse	
Stress		Relationship issues	
Abuse (physical, emotional, sexual)		Parenting concerns	
Trauma		Psychosis	
Neglect, abandonment		Sexual dysfunction	
School/Work difficulties		Gender identity problems	
Anxiety		Other (please describe)	
Anger			

Symptoms (Check all that apply):

Change in appetite		Lack of boundaries	
Change in sleep patterns		Racing thoughts	
Sadness		Panic attacks	
Low self-esteem		Anger outbursts	
Lack of motivation		Poor impulse control	
Increased energy level		Physical aggression	
Social isolation		Destruction of property	
Excessive worry		Self-abusive behavior	
Excessive guilt		Erratic behavior	
Crying spells		Obsessive thoughts	
Difficulty concentrating		Compulsive behavior	
Weight loss/gain		Paranoid thoughts/delusions	
Poor hygiene		Hallucinations	
Decline in school/work performance		Alcohol or Drug dependence	
Flat emotions		Other (please describe)	
Impaired memory			

Briefly describe presenting problem: _____

When did the presenting problem(s)/symptoms(s) begin? _____

How often are the above symptoms experienced? _____

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On a scale of 1-10 with 1 being the least and 10 being the most, how intense are the symptoms?

1 2 3 4 5 6 7 8 9 10

Briefly describe how the above problem(s)/symptoms(s) are negatively affecting the client's:

- **Daily Functioning:** _____
- **Family Relationships:** _____
- **Social Relationships:** _____
- **Functioning at work/school:** _____

Has the client ever received any treatment for these problem(s)/symptoms(s)? Y N

If yes, when? Where? Who was your doctor or therapist? _____

How long did the treatment last? _____

What was the outcome of the treatment received?

Please list any history of psychiatric hospitalizations:

Date	Location	Outcome
_____	_____	_____
Date	Location	Outcome
_____	_____	_____
Date	Location	Outcome
_____	_____	_____

Family psychiatric history—please include any mental health diagnosis given to immediate family members:

Client's medial history—please briefly describe any significant illnesses, hospitalizations, surgeries: _____

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Please list any other significant adults or children in the client's life—please include nature of relationship:

Client's marital status (if applicable):

Single _____
Married _____ How long? _____
Divorced _____ How long ago? _____
Separated _____ How long ago? _____
Widow/Widower _____ How long ago? _____
Other _____

Trauma/Abuse History—please describe any significant trauma(s) experienced or witnessed by the client or any significant trauma(s) within the family:

Please describe any history of significant life events such as deaths, separation from parent(s), frequent moves, terminal illnesses within the family or close friendships:

Relationship History (if applicable):

Is the client currently dating? _____ at what age was your first date? _____
Is the client sexually active? _____ at what age was your first sexual encounter? _____

Cultural Influences

With what ethnic/cultural group(s) does the client identify with? _____

With what ethnic/cultural group(s) does the client's family most identify? _____

Describe any cultural values or beliefs that may impact treatment: _____

Educational History (for children and college students)

Current school attending _____ Grade _____ Highest degree earned _____

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Average grade performance: _____

Overall motivation to attend school: _____

Extracurricular activities: _____

Employment History (if applicable):

Current employment status—Where, how long? _____

Positive/negative aspects of current position? _____

Please list any special interests/hobbies/skills client has: _____

Please list the client's strengths: _____

Describe desired treatment goal(s):

Please share any additional information that may be important for me to be aware of:

Client or Parent/Guardian Signature

Date