



**Woodlands Family Institute, P.C.**

1610 Woodstead Ct., Suite 420  
The Woodlands, TX 77380

(281) 363-4220 Fax: (281) 363-4010  
www.woodlandsfamilyinstitute.com

**PERSONAL DATA RECORD**

Client Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ TXDL: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Referred to Our Office by: \_\_\_\_\_

May we send a Thank You card to the person who referred you? (Circle One) Yes No

May we mention your name in that Thank You card? (Circle One) Yes No

**INSURANCE INFORMATION**

Insured Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Client \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's SSN \_\_\_\_\_

Policy No.: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone \_\_\_\_\_

**INSURANCE INFORMATION  
section not applicable to  
clients of Christie Farris**

**If you would like us to auto-charge your credit card for your fee or copayment, please complete the authorization information below:**

MC/Visa No. \_\_\_\_\_ Exp. Date \_\_\_\_\_

Name as Listed on Card: \_\_\_\_\_

Signature of Authorized User: \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address/Phone: \_\_\_\_\_

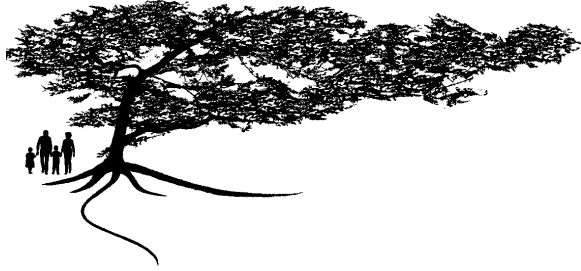
**FINANCIAL RESPONSIBILITY**

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

Address(es): \_\_\_\_\_

Signature(s): \_\_\_\_\_

Relationship(s) to client: \_\_\_\_\_



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**Consent for Treatment**

Client Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

I give full consent for myself or my child/adolescent to receive outpatient mental health services until I notify WFI of any changes or until it is determined that treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for myself or my child/adolescent.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

**Authorization to Pay Benefits**

I request that payment of authorized insurance benefits be made on my behalf to Woodlands Family Institute, P.C. for professional services rendered to me or my dependent. The undersigned is financially responsible for fees not paid pursuant to this agreement. I authorize any holder release of medical information as may be required for the completion of my claims. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of client: \_\_\_\_\_

Signature of insured: \_\_\_\_\_

Date: \_\_\_\_\_

## Notice for Clients of Christie Farris, LPC-I, LMFT-A

Clients should note that I am currently a licensed professional counselor intern and a licensed marriage & family therapy associate, which means that I have fulfilled the requirements for licensure except for the completion of the required number of client contact hours. During my internship, I will remain under the supervision of Judith A. DeTrude, PhD, LPC-S, LMFT and, if necessary, she can be reached at 281-435-7275.

Please sign below indicating you understand and accept this notice:

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Client Signature

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Date

---

Witness

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Date



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### 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.
- **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 4/14/2003. 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

- Refused to Sign
- Unable to Sign (Specify Reason) \_\_\_\_\_

\_\_\_\_\_  
Signature of Person Documenting Refusal or Inability to Sign Date