Woodlands Family Institute, P.C.

Becky Dicharry, M.Ed
Licensed Professional Counselor

PERSONAL DATA RECORD

Client's Name ___________________________ Date of Birth __________________

Parent's name if client is a minor: ____________________________________ _____

Address: ___________________________________

____

SSN ______________________________ TXDL _____________________

Employer/School ____

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

Home phone ___________________________ May we leave a message? Yes No

Work phone ___________________________ Yes No

Cell phone (circle one) ___________________ Yes No

Unencrypted email address ________________ Yes No

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

____

____

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 ____

Address____

Phone ________________________ Relationship to client __________________

1610 Woodstead Court, Ste. 420
The Woodlands, TX 77380
Phone: 281-363-4220 Fax: 281-364-9404
www.wfipc.com

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PAYMENT INFORMATION

Name of person financially responsible for this account: ______________________

Address____

Phone ________________________ Relationship to client __________________

Signature: ___________________________

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 ____

INSURANCE INFORMATION:

Insured Name: ___________________________ Relationship to Client:_____________________________

Date of Birth: ____________ SSN: _____________________

Insured's Employer: __________________________________

Insurance Company: _________________________________

Address: ____ Phone: _______________________________

Policy #: ____ Group #:______________________________

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/legal guardian: _____________________________ Date: _______________

Signature of insured: ____ Date: _______________

You may change the above instructions at any time by requesting another form or otherwise instructing in writing.

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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

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GENERAL INFORMATION

We are honored that you have selected the Woodlands Family Institute to provide counseling or psychological services. All of us wish to do our best to assist you in making this experience meaningful for you. This document is designed to inform you about my background and to ensure that you understand the treatment process and our professional relationship.

I hold a Master's of Education in Counseling and am licensed by the state of Texas as a Professional Counselor. I am also a Board Certified Professional Counselor through the American Psychotherapy Association.

I believe that no matter how difficult a person's circumstances may be it is possible to produce meaningful change. For some, change happens within a few sessions while for others it may take months or even years. Individuals change when they are comfortable and believe it is safe to do so. As your counselor, my goal is to provide you with a safe, non judgmental environment so that you feel comfortable enough to identify and work on areas of needed change, psychological pain or areas of dissatisfaction in your life. As the client, you are the expert and are in control of our relationship. You may end our professional relationship at any time and I will be supportive of that decision.

The counseling process is a mutual partnership between you and me. I value the counselor/client relationship and encourage you to actively participate in the treatment process in order to maximize the potential for creating positive growth and change in your life. This involves keeping all scheduled appointments, being forthright about your issues and goals, and remaining open and honest during the treatment process. I strive to take into account the specific needs of each individual client and welcome your input throughout treatment.

My approach to counseling is strength based and incorporates a range of therapeutic techniques. Some of these include helping you to identify negative thought and behavior patterns while teaching you healthy coping strategies in order to create balance and provide hope and support as you work through challenging issues.

Therapy has been shown to have many benefits. It often leads to better relationships, practical solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience while in therapy. While therapy can be beneficial to most individuals, the process is not always helpful. Please be aware that the work you do in session may evoke strong emotions and sometimes influence unanticipated changes in one's behavior. It is very important that you discuss any questions or discomfort you experience. I may be able to help you understand the experience or use a different approach that may be more satisfying.

Although our sessions may be very intimate psychologically it is important to remember that our relationship is professional rather than social. In order to maintain a professional relationship with you our contact will be limited to sessions you arrange with me. I am unable to accept gifts or attend social events if invited. I want your sessions to be as safe and secure as possible so that we can concentrate exclusively on your concerns. If I see you in a public setting, it is my practice to allow you to choose whether or not you want to acknowledge me. I will be respectful of your decision and will not be offended should you choose not to acknowledge me.

I assure you that our work will be conducted in a conscientious manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results. If at any time you are dissatisfied with my services please let me know.

If in the unlikely event of my death or incapacitation, your records will become property of the Woodlands Family Institute.

Woodlands Family Institute, P.C.

Becky Dicharry, M.Ed
Licensed Professional Counselor

OFFICE POLICIES

_______ **(Initial) Payment**: Clients are expected to pay for services at the time they 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.

> ***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.***

_______ **(Initial) Standard Rates:** My regular fee is $140.00 for a 50 minute session. Charges for other professional services are prorated on the basis of $140.00 per hour, billed in 15 minute increments. These services include, but are not limited to, phone calls, insurance reports, third-party consultations, and correspondence. Off-site consultation is prorated at the rate of $140.00 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 so 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 <u>payable in advance</u>.***

_______ **(Initial) 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.***

______**(Initial) Cancellations:** The scheduling of an appointment involves the reservation of time especially for you. Therefore, **<u>24 hours</u>** cancellation notice is required in order for you to avoid being charged in full for the missed appointment. ****Please note that insurance companies do not reimburse for missed appointments***.

_____ **(Initial) Confidentiality**: The law protects the privacy of all communications between clients and counselors. 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 that 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.

OFFICE POLICIES CONTINUED

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 consolations 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.

_____ (Initial) Limits to Confidentiality

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

1. You direct me to disclose information to someone else
2. If you determined to be in imminent danger of harming yourself or someone else
3. I am ordered by a court or regulatory body to disclose information
4. You disclose abuse or neglect of children, the elderly, or disabled persons
5. In the instance of reasonable suspicion of child or elder abuse
6. The need to release information to other professionals involved in your treatment
7. In proceedings in which a claim is made about one's physical, emotional, or mental condition.
8. When disclosure is relevant in any suit affecting the parent-child relationship This includes divorce and child custody deliberations.
9. In legal or regulatory actions against a professional.
10. Where otherwise legally required
11. If you are under 18, your parents or legal guardian(s) may have access to your
12. If you disclose sexual misconduct by a therapist
13. 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).***

_____ (Initial) Miscellaneous:

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

- We respectfully request that your cell phone be turned off during your session.

- Standard office hours are Monday-Thursday 8 a.m.-6 p.m. and Friday 8 a.m-4 p.m. Any other time is considered "after hours" and may be charged at 1 ½ times my standard rate.

- If a **TRUE** emergency arises after hours, please contact our answering service at 713-866-4494.

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.

______________________________ ______________

Signature **Date**

Woodlands Family Institute, P.C.
1610 Woodstead Court, Ste. 420
The Woodlands, TX 77380
Phone: 281-363-4220 Fax: 281-364-9404

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.

Woodlands Family Institute, P.C.

Becky Dicharry, M.Ed

Licensed Professional Counselor

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.

Becky Dicharry, LPC, BCPC

Initial Assessment

Client's Name: ______________________________ **Age:** ________ **Date**: __________________

Parent/Guardian Name (if client is a minor*):*

____

Presenting Problems: (Please check all that apply)

Adjustment issues		Grief/loss	
Depression		Relationship issues/marital discord	
Suicide/homicide gesture, attempt or ideation		School/work related issues	
Stress		Parenting concerns	
Anger		Substance abuse	
Unstable mood		Psychosis	
Anxiety		Gender identity problems	
Trauma		Sexual dysfunction	
Neglect, abandonment		Other: (please describe)	
Abuse (physical, emotional, sexual)			

Symptoms (Please check all that apply)

Low self-esteem		Racing thoughts	
Social isolation		Panic attacks	
Sadness		Irritability/agitation	
Change in appetite		Anger outbursts	
Excessive worry		Poor impulse control	
Disturbance in sleep		Physical aggression	
Crying spells		Destruction of property	
Excessive guilt		Self-abusive behavior	
Difficulty concentrating		Erratic behavior	
Weight loss/gain		Obsessive thoughts	
Poor Hygiene		Compulsive behavior	
Lack of motivation		Hallucinations (auditory, visual, tactile)	
Loneliness		Paranoid thoughts, delusions	
Flat emotions		Alcohol Drug Dependence	
Impaired memory		Decline in work/school performance	
Increased energy level		Other: (Please describe)	
Lack of boundaries			

Briefly describe the presenting problem:

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

How often does the client experience these symptoms(s)?

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

1 2 3 4 5 6 7 8 9 10

Briefly describe how the above problems/symptoms are negatively affecting client's:

Daily Functioning: ____

Family Relationships: ____

Social Relationships: ____

Functioning at school/work: ____

Has the client received a diagnosis or treatment for these issue(s) or any other mental health related issues prior to today? ____NO _____YES

If Yes: When? ______________________ Where? _____________________________________

Who was the client's doctor or therapist? ____

How long did the treatment last? ____

What was the outcome of the treatment the client received? _______________________________

Please list any history of psychiatric hospitalizations:

Date____________________Location__________________Outcome______________

Date____________________Location__________________Outcome______________

Family psychiatric history-please include any mental health diagnosis given to the client's <u>immediate family members</u>:

____

____

<u>Client'</u>s medical history-please briefly describe any significant illnesses, hospitalizations, surgeries:

____

____

<u>Family</u> medical history-please briefly describe any significant illnesses, hospitalizations, surgeries:

____

____

Drug and Alcohol Abuse
Does the client have a history of drug/alcohol usage/abuse? If yes, please describe the abuse and any treatment received:

____

____

Is there any **family** history of drug and/or alcohol usage? If yes, please list and describe:

____

Client's current doctor(s) ***(Please list all doctor's that client sees on an ongoing basis)*****:**

____

Please list client's current medications (*Prescribed and over the counter*)

Name of Medication	Prescribed for	Prescribing Doctor

Client's Family History-include spouse, significant other, children, parents, step families, adoption history*:*

Name	Relationship	Age	Living where?

Please list any other significant adults or children in the client's life (*Please include type of relationship-i.e supportive, conflictual, etc.):*

____

Client's marital status: (***If applicable***)
Single ______ Married _____ Separated _____ Divorced ______ Widow/widower____

Trauma History-please describe any significant trauma(s) experienced or witnessed by the client:

____

____

Please describe any history of trauma within the family:

____

____

Please provide details of any history of *significant life events* such as deaths, separation from parent(s), frequent moves, terminal illnesses in the family or close friendship:

____

____

Cultural Influences:

With what ethnic/cultural groups does the client identify with? ____________________________

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

Client's Educational History: (*For children and college students*)

Current School attending____________________________

Current Grade_______ Highest degree earned_____________ Average grade performance _______

Overall motivation at school ____

Extracurricular activities____

Client's Employment History: ***(If applicable)***

Present employment status--Where, how long?

____

Positive/negative aspects of current position

____

Please list client's special interests/hobbies/skills:

____

Please list the client's strengths:

____

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Describe desired treatment goal(s):

____

____

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

____

____

____

_____________________________________ ________________

Client's Signature **Date**