Josh Parham, MA, LPC
Licensed Professional Counselor

PERSONAL DATA RECORD

Client Name: ______________________________________ Date of Birth: _____________

Address: ____

City/State/Zip: ____

SSN# ___________________________ TXDL# ___________________________

Employer/School/Address: ____

May we leave a message at any of the following?

Home Phone _________________________ May I leave a message (circle one)? Yes No

Work Phone _________________________ May I leave a message (circle one)? Yes No

Cell Phone ___________________________ May I leave a message (circle one)? Yes No

Unencrypted email address: ____

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

Alternative Address: ____

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

Credit Card Payment Authorization for Auto Charge

If you would like us to automatically charge your credit card at the time of each service, please complete the authorization information below:

Name (as listed on card) ____

MC/VISA No. ____ Exp. Date _____________

Signature of Authorized User ____

INSURANCE INFORMATION

Insured name: ____ Date of Birth: ___________________

Relationship to Client: _________________________________ Insured SSN: ____________________

Insured Employer: ____

Policy No. _____________________________________ Group No. ___________________________

Insurance Carrier: ________________________________ Carrier Phone: _______________________

FINANCIAL RESPONSIBILITY

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

Address(es): ____

Signature(s): ____

Relationship(s) to client: ____

EMERGENCY CONTACT

Name: ___________________________________ Relationship: __________________

Address/Phone: ____

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 Woodlands Family Institute, P.C. 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.

____ _____________________________

Signature of Client or Client's Parent or Legal Guardian Date

INFORMATION, CONSENT, AND POLICIES

I am honored you have asked me to help you by providing counseling services. I will do everything I can to make this experience as meaning and fruitful as possible. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I have a Bachelor's Degree in Psychology, and a Master's Degree in Clinical Psychology. I have been a Licensed Professional Counselor since 2005. I believe that no matter how difficult a person's circumstance may be, it is possible to produce meaningful changes. Sometimes this takes a long time to achieve. While some clients need only a few sessions to reach their goals, others may require months or even years. As a client, you are in complete control and may end our professional relationship at any point. I will be supportive of that decision. Ultimately, my job is to work myself out of a job, so that you feel confident to carry on without my intervention.

This process is a partnership between you and me to work on areas of dissatisfaction in your life or to assist you with life goals. For this to be most effective, it is important that you take an active role in the process. This involves keeping scheduled appointments, being forthright about your issues and goals, and openly discussing the process with me. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. While counseling or psychotherapy can benefit most people, the process is not always helpful. Sessions can evoke strong emotions and sometimes influence unanticipated changes in one's behavior. It is important that you discuss with me any questions or discomfort you may have during the process. 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 for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you arrange with me. It may be confusing and counter-productive for me to accept gifts or be invited to social gatherings. So please do not ask me to relate to you in any way other than in the professional context of our sessions. I want your sessions to be as safe and secure as possible so that we can concentrate exclusively on your concerns. You are best served by experiencing me in my professional role. If at any time you are dissatisfied with my services, please let me know.

Children can be joyful and energetic, but with respect to the concerns which brought you to me, I request that you obtain a sitter for children not receiving treatment so that our full attention can be devoted to your priorities.

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 for you.

Please be aware that I do **not** provide consultation, evaluation, or legal testimony in child custody, child visitation, or molestation cases. If you require these services, I will be happy to refer you to professionals who work with these issues.

OFFICE POLICIES

FEE SCHEDULE:

Standard rate: $140.00 per standard 45 minute session. Cash or personal checks are accepted. This rate also applies to other professional services, prorated on the basis of $140.00 per hour ($2.33 per minute). These services include, but are not limited to, phone calls, insurance reports, third-party consultations, and correspondence.

PAYMENT POLICY:

Payment is due in full at time of service. Please make out your check before the session begins. Checks should be made out to: Woodlands Family Institute. Cash and major credit cards are also accepted. It is not my policy to carry balances forward. I expect balances for "forgotten checkbooks" or forgotten appointments" to be made up promptly or by the next scheduled appointment at the latest. If an outstanding balance accrues, you will be billed on the first of the month assessed a 2% finance charge, compounded monthly. There is $10.00 rebilling fee for every statement sent out after the first billing. There is also a $25.oo 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 and will impact your credit rating.

INSURANCE:

I currently accept clients with Aetna, Blue Cross/Blue Shield of Texas PPO, and ValueOptions insurance.

CANCELLATIONS:

Since the scheduling of an appointment involves the reservation of time specifically for you, 24 hours advance notice for any cancelled appointments will not be charged. If you are unable to meet this time schedule, but if I am able to assign your appointment time to another client, you will not be charged. Please note that insurance companies do not reimburse for missed appointments. **Please call the WFI for cancellations, as email is not monitored daily for cancellations.**

OFFICE HOURS:

I currently see clients Monday through Friday by appointment only.

EMERGENCIES:

It is assumed that outpatient clients are self-responsible, autonomous, and not in need of day-to-day supervision. Outpatient clinicians cannot assume responsibilities for client's day-to-day functioning, as can agencies or inpatient hospital settings. Nevertheless, in the event that an emergency occurs, leave a message at 281-363-4220 making sure to state that your call is an emergency. I will respond to your call as promptly as possible. If I am unable to respond quickly enough, please call 911 or go to your local emergency room.

CONFIDENTIALITY:

The law protects the privacy of all communications between a client and psychotherapist. 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 law. Your signature on the Acknowledgement form provides consent for those activities, as follows:

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 confidential. These consultations are very commonplace and routine and may not be ordinarily mentioned in our sessions, unless it seems important to our work together. If you would prefer this be handled differently, please let me know.

I will keep confidential anything you say to me, with the following exceptions: a) you direct me to tell someone else; b)I determine that you are a danger to yourself or others; c) I am ordered by a court or regulatory body to disclose information; d) you disclose abuse or neglect of children, the elderly, or disable persons; e) the need to release information to other professionals involved in your treatment; f) in proceedings in which a claim is made about one's physical, emotional, or mental condition; g) when disclosure is relevant in any suit affecting the parent-child relationship; h) 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 third parties. **Please note: Third-party insurance companies require submission of diagnosis and specific clinical data. If you elect to use insurance or managed care to cover part of the cost of your sessions, please be aware that I will be required to provide that information.**

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 psychotherapy.

____ _____________________________

Signature Date

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

Josh Parham, LPC 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 I 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 I obtain reimbursement for your health care. 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 the practice of Josh Parham, LPC such as utilizing information that identifies you.
- *"Disclosure"* applies to activities outside of the practice of Josh Parham, LPC, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I 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 I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I 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) I 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 policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or any local or state law enforcement agency.

- **Abuse of the Elderly and Disabled:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a therapist:** If you report to me any situation that constitutes sexual misconduct by a current or former therapist, then I am 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 the 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 I 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 I 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, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and My 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, I am 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 my services. Upon your request, I 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. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I 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. I may deny your request. On your request, I 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 the Notice). On your request, I 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.

My Professional Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, I am required to abide by the terms currently in effect.
- If I revise the policies and procedures, I will post a current copy in my office. You may request a personal copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at (713) 492-8834.

If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to Josh Parham, LPC at: 50 Sugar Creek Center Boulevard, Suite 250, Sugar Land, Texas 77478.

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

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice goes into effect 6/1/2010. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice upon request, and it will be posted in the office.

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. Josh Parham, LPC 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

Please take a moment to complete the Presenting Problems and Symptoms sections of the enclosed treatment plan.

We will review these together and complete the remainder of the plan in our initial session.

Treatment Plan

Date: ___________

Name: _______________________________

Presenting problems:

____Depression _____Anxiety _____Relationship Discord
____ Stress _____Alcohol ____Obsessive/Compulsive ____Bereavement
____Parenting _____Sexual ____Psychosis _____Adjustment Issues
____School/Work Issues ____Other (please describe)

Description:

Symptoms:

___appetite ___sleep ___sadness ___self-esteem ___motivation ___energy
___hygiene ___agitation ___hyper ___worry ___social isolation ___tearful
___racing thoughts ___panic attacks ___obsessive thoughts
___compulsive behaviors ___flat emotions ___concentration ___memory
___weight loss/gain ___confidence ___loneliness ___excessive emotionality
___hallucinations ___delusions ___erratic behavior ___alcohol/drug dependence
___other (please describe)

Description:

Treatment Goals:

1. Reduce frequency and intensity of:
2. Increase frequency and intensity of:
3. Eliminate:

Treatment Methods and Duration:

___Individual sessions weekly using CBT and/or relaxation techniques

___Relationship sessions weekly using CBT and application of research findings

Diagnosis:

Axis I ______
Axis II ______
Axis III ______
Axis IV ______
Axis V ______

Recommendations of Adjunctive Treatment/Assessment:

Plan review/Revision:

________________________ ________________________
Josh Parham, LPC Client