Office: 832-767-0760 Fax:832-553-7274

Email: info@providentialcounseling.com

CONFIDENTIAL INFORMATION SHEET

This information is to help us better understand you and your situation. Please fill it out as completely as you can. All information will be held in strict confidence.

Date: _____/_____/_____

CLIENT INFORMATION:

NAME: _____ Birthdate: _____/_____/_____

Address: _____ City: _____ Zip:_____

Home Phone: _____ Work Phone: _____ Mobile: _____

Sex: _____M _____F Marital Status: _____ Email:_____

Referred by:_____

INSURANCE INFORMATION:

Insurance Carrier: _____ Phone: ( )_____-_____

Employer: _____ ID# _____ Group #_____

Insured's Name: _____ SSN: _____-_____-_____ Insured's DOB:____/___/__

Name of Employee Assistance Program: _____

Authorization #: _____

RESPONSIBLE PARTY INFORMATION:

Name:_____ Email:_____

Relationship to Client: ___Self ____Spouse____Child____ Other (please indicate):_____

Address:_____ City: _____ Zip:_____

Home Phone: _____ Work Phone:_____ Mobile:_____

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1. I, the undersigned, accept financial responsibility for payment of all fees at the time of visit, unless other arrangements have been made.
2. AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize the release of any information regarding my/my child's condition or treatment to insurance company.
3. AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.

SIGNATURE:_____ DATE:_____
(Client or Parent of Minor)

GENERAL INFORMATION AND PROCEDURES

Length of Session: 50 minutes

Cancellations: Your session time is reserved for you and is taken seriously. Cancellations must be made 24 hours in advance. There is a $50 fee for no-shows or cancellations in less than 24 hours. If no one is available, please leave a message @ 832.767.0760, reply to the reminder text/voicemail, or email at info@providentialcounseling.com. If Medicaid is your insurance provider, we will refer you to another provider after 2 no-shows/cancellations.

Fee Structure: The client is financially responsible for payment of fees, which will be collected at the time of service. The client will also be responsible for any portion of fees not reimbursed or covered by health insurance. If your insurance stops or changes, let us know prior to your scheduled session. In the event of an accrued balance, the client and therapist can negotiate a payment schedule.

Confidentiality: Information shared in session is held in the strictest confidence according to federal law (Regulation 42 CFT Part 2). Exceptions include: legal obligations (such as child abuse, elder abuse, testimony required by a judge, personal danger to self or others) and information provided to parents if client is a minor. Advice may be solicited from professional peers in regard to your case, without revealing identity. Release of information to other professionals may be done only with your written consent.

Client Privacy: Recent laws have been enacted for client privacy. It is important to know that emails and mobile phone conversations are not secure or guaranteed of privacy because they can be potentially intercepted. Therefore, by signing this document you understand that if we have correspondence by email or mobile phone, there is a potential for confidentiality to be compromised.

Counseling Approach: To get the most of counseling and/or evaluations, it is important to assume responsibility for your experience. Therapists can only help based on the information you provide. If you are like most people, you probably have some sensitive issues you are not comfortable discussing with others. Those are usually the things you would want to talk with your therapist about. Depending on the circumstances, you may be asked to include some family members in your treatment. Regular, consistent participation in treatment sessions, as well as any "homework" assignments, will help facilitate the process. However, no therapist can ethically guarantee achievement of your goals. Please feel free to ask questions about the process and let me know if you are dissatisfied with how things are progressing. Due to the nature of the therapeutic process, you may experience periods of emotional discomfort on the way to your goals. No single therapist is best for every client. If you do not feel that I am the right therapist for you, I will be happy to help you with a referral. You are free to discontinue treatment at any time.

_____ _____

Client &/or Parent Signature Date

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Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the information about therapy. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged $50 for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client /parent/guardian (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

Credit Card Agreement

I have provided Providential Counseling & Consulting Services, PLLC with my credit card number and authorize them to keep my signature on file, and to charge my credit card account for psychotherapy services, missed appointments, balances, and insurance claims.

My credit card will be charged each time a service is provided unless I decide to pay in cash, debit, credit card, or through the use of a flex spending account. In the event that my insurance does not cover all expenses, I am responsible for amounts they do not cover after the office's attempt to recoup. For your convenience, Providential Counseling & Consulting Services, PLLC will wait a reasonable amount of time to be reimbursed by your insurance carrier for services delivered.

I am giving Providential Counseling & Consulting Services, PLLC permission to charge my credit card for any services that have not been paid by myself or my insurance carrier within sixty (60) days of billing. If services have not been paid within 60 days, Providential Counseling & Consulting Services will notify me in writing that they have not been paid by my insurance carrier and they will encourage me to contact the carrier in order to get them to pay for the services in a timely manner.

We charge $25 for any fraudulent credit card charge backs. Confidential information may be disclosed to collect monies owed. If suitable arrangements for payment
have not been agreed upon and your account has not been paid for more than 60 days, I have the option of using legal means to secure payment, including but not limited to collection agencies or small claims court.

I understand that this form is valid for one year unless I cancel authorization through written notice to Providential Counseling & Consulting Services, PLLC. By signing below, I acknowledge that I am the card holder and responsible for payments in accordance with this document.

Name On Card: _____
Type of Card (visa, discover, master card):_____
Card Number: _____
Expiration Date: _____

Grievances

The clinician will provide services in a professional manner consistent with all applicable laws, rules, regulations, guidelines, and codes of ethics concerning the therapist and the therapist/client relationship. Any dissatisfaction with services or other complaint should be discussed with the therapist. If you do not believe your complaint was handled in a satisfactory manner please contact Richelle Whittaker, LPC-S, the owner of Providential Counseling & Consulting Services, PLLC at (832) 767-0760.

Depending upon the clinician's credentials, you may also formally file a complaint about a clinician to:

Texas State Board of Examiners of Professional Counselors
1100 West 49thStreet
Austin, TX 78756-3183
(512) 834-6658

Texas State Board of Social Worker Examiners
PO Box 141269
Austin, TX 78714-1369
(512) 719-3521

Texas State Board of Examiners of Psychologists
333 Guadalupue Suite 2-450
Austin, TX 78701
(512) 305-7700

By signing below, I acknowledge that I have read, understood, and agree to everything in this agreement.

_____ _____

Signature of client Date

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Client Rights

Right to request how we contact you
It is our normal practice to communicate with you at your home address and daytime phone number you provided on your intake forms, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way. May we contact you at home (circle one) **Yes/ No**? May we contact you at work **Yes/ No?**. May we contact you by cell phone **Yes /No?** Where may we contact you _____?

Right to release your medical records
You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization

Right to inspect and copy your medical and billing records
You have the right to inspect and obtain a copy of your information contained in our records. To request access to your billing or health information, contact the office manager. Under limited circumstances, we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing, and supplies.

Right to add information or amend your medical records.
If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request within 60 days, or some cases within 90 days. Under certain circumstances, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.
You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information.
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Right to complain.
If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy.
You have the right to receive any future policy changes secondary to changes in state and federal laws.

I understand my rights and agree with the information provided.

_____ _____

Client and/or Guardian Signature Date

HIPPA 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 INFORMATIION. PLEASE REVIEW IT CAREFULLY.

Effective date: April 14, 2003

Providential Counseling and Consulting Services is totally committed to maintaining client's confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services, which could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Texas State Law, we are obligated to report this to the Department of Children and Family Protective Services. If you provide information that informs us that you are in danger of harming yourself or others. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.


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