Counseling Resource Center
500 Mason
Tomball, Texas 77375

Minor Consent Form

I,_____ give consent for Counseling Resource Center to counsel with my child _____.

Parent Signature: _____

Date: _____

Texas State Board of Examiners of Professional Counselors Title 22, Texas Administrative Code, Chapter, 681, effective June 1, 2012

681.41 (aa)

Prior to the commencement of counseling services to a minor client who is named in a custody agreement or court order, a licensee shall obtain and review a current copy of the custody agreement or court order, as well as any applicable divorce decree. A licensee shall maintain these documents in the client's record.

Child

CLIENT HISTORY

Physical Complaints Yes/No

Sleeping? _____
Headaches _____
Heart palpitations (races) _____
Shortness of breath _____

Nightmares? _____
Stomachaches _____
Weight loss or gain _____
Panic attacks _____

Do you use alcohol or drugs? _____
If yes, how much used per week? _____

Client Presentation

Frustrated ___
Fearful ___
Eating disorder ___
Argumentative ___
Low energy ___
Problems at work ___
Crying spells ___
Thoughts of suicide ___

Talkative ___
Irritable ___
Abuse survivor ___
Impulsive ___
Racing thoughts ___
Hearing voices ___
Seizures ___

Nausea ___
Distracted ___
Avoiding ___
Depressed ___
Anxious ___
Dizziness ___
Feel worthless ___

Fatigued ___
Rage ___
Withdrawn ___
Feel Guilty ___
Angry ___
Light headed ___
Restless ___

FAMILY HISTORY

Please List All Members of Your Household:

Name - Relationship	Birthdate - Age	Sex
1.		
2.		
3.		
4.		
5.		
6.		

If Client is a minor complete this section. Fill in all that apply.

Birth Mother's Name _____
Birth Father's Name _____

Step Father's Name _____
Step Mother's Name _____

Name of responsible party _____
Street Address of responsible party _____
City, State, Zip _____

Who brought minor child for counselling? _____
Who is the legal guardian for minor client? _____
What is your relationship to minor client if none of the above? _____

If divorce or a temporary order has precipitated custody arrangements, please provide a copy ASAP, particulary if one parent is sole conservator. If applicable, who is the sole conservator? _____

Child

Client Information

Date _____

Name _____ Date of Birth _____

Address _____ City _____ Zip _____

May we send mail to this address? __ Yes __ No

Telephone Number Home _____ Cell _____

May we contact you at this phone number? __ Yes __ No. May we leave a message __Yes __ No

E mail _____

May we send appointment reminders (only) to this e mail address? __ Yes __ No

In Case of Emergency Notify _____

Purpose of Visit _____

Employer's Name _____

Physician's Name _____

Physician's Telephone Number _____

Medications

_____

_____

Have you been to counseling before? _____

Where did you hear about us? _____

Counseling Resource Center

Statement of Financial Responsibility/Agreement of Benefits

Counseling Resource Center

I acknowledge that I am legally responsible for all connection with the medical/behavioral care and treatment provided by representatives of Counseling Resource Center. I assign and authorize payments to Counseling Resource Center. I understand my insurance carrier may not approve or reimburse my medical/behavioral services in full due to usual and customary rates, benefits exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductions and co-insurance except where any liability is limited by contract or State or Federal Law.

Signature of Client or Guardian _____ Date _____

Printed Name of Client or Guardian _____ Relationship to Client _____

500 Mason • Tomball, Texas 77375 • 281-255-9922

Parent

Client Information

Date _____

Name _____ Date of Birth _____

Address _____ City _____ Zip _____

May we send mail to this address? __ Yes __ No

Telephone Number Home _____ Cell _____

May we contact you at this phone number? __ Yes __ No. May we leave a message __Yes __ No

E mail _____

May we send appointment reminders (only) to this e mail address? __ Yes __ No

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Parent

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Step Mother's Name _____

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Information and Professional Services Informed Consent

Thank you for choosing Counseling Resource Center. Today's appointment will take approximately 45-50 minutes. We realize that coming to counseling is a major decision and you may have many questions. Today's session will include discussion about counseling practices, limitations, and risks. This document informs you of your rights, our policies, state and federal laws. If you have other questions or concerns, please feel free to ask.

Confidentiality

You have the right to confidentiality. No information will be released without your written consent except as required by law. Such exceptions to confidentiality include:

1. We believe you are in imminent danger of hurting yourself or others.
2. By Texas State Law, we are obligated to report information concerning child and/or elder abuse to the Department of Children and Family Services.
3. We are required by law to release information such as a court ordered subpoena.
4. We may need to disclose 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.
5. If your therapist is a Licensed Professional Counselor Intern or a therapist with a Temporary license they are under the supervision of a Licensed Professional Counselor Supervisor. During supervision, a therapist may disclose certain information with their respective supervisor who then shares the obligation for confidentiality.
6. The counseling staff at the Counseling Resource Center also works as a team and your therapist may consult with other therapists and supervisors to provide the best possible care for their clients. All therapists and supervisors are held to the same confidentiality agreement.

Under the Health Insurance Portability & Accountability Act (HIPAA), you have certain rights to privacy regarding protected health information. You have, also, been given the HIPAA requirements concerning privacy policies. This information can and will be used to:

1. Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

The owner of Counseling Resource Center is the custodian of the client files. They are maintained according to HIPAA guidelines and State law. In the event of a Counselor's death, disability, retirement or inability to provide counseling services, the owner of Counseling Resource Center will possess and maintain the clinical records.

Emergency Contact

At Counseling Resource Center, we do not provide crisis intervention or intensive crisis counseling. If you have a crisis after office hours, please contact your physician, call the crisis hotline at 713-468-5463 (713-HOTLINE), or go to the nearest emergency room. If hospitalization occurs, please contact our office during business hours.

Payment Information

All Counseling Resource Center Counselors are professionals, licensed with the State of Texas. There is a set fee for each session that is due prior to the appointment. Please speak to your counselor in the initial session to obtain a clear understanding of the fee.

I, _____, *have a clear understanding of the fee I will be charged.* _____

Client's printed Name

initials of client

Financial/Insurance Issues

As a courtesy, we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. Your co-pay is required at each session. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, you are required to pay the balance at that time. After 60 days an unpaid balance will be charged 1.5% interest/month. In the event that an overdue account is turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to the Counseling Resource Center.

Returned Check

A $45.00 fee will be assessed for any returned check to cover the bank fees.

Letter/Paperwork Fee

A $50.00 fee will be assessed for correspondence required for legal matters including, but not limited to, documentation for court, CPS, or lawyers. Additional fees may apply for other paperwork requested, appearances in court, or other entities.

Termination of Counseling

Discussion and action toward counseling termination and/or referral will be conducted when:

1. Counseling goals have been achieved
2. You no longer want counseling or do not return for counseling
3. You are no longer benefitting from counseling
4. Counseling would otherwise not be in your best interest

Cancellations

Please provide a 24 hour notice of cancellation. The advanced notice is standard practice in the counseling profession. Failure to provide notice will result in a cancellation fee of $60.00. Counseling Resource Center has a 24 hour answering machine to assist you in cancelling in a timely manner.

Your signature below indicates you have read and understand this policy and have received the HIPAA Privacy Notice.

_____ _____

Client's/Legal Representative's printed name Date

_____

Client's/Legal Representative's Signature

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 INFORMATION. PLEASE REVIEW CAREFULLY.

WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

Counseling Resource Center is committed to providing services designed to meet your needs. We are equally committed to respecting your privacy and protecting the information about you that we may receive. We have prepared this notice to advise you what information we collect, how we use it and how we protect it.

We are legally required to protect the privacy of your health information. We call this information "protected health information," or "PHI" for short, and it includes information that can be used to identify you that we've created or received about your past, present or future health or condition, the provision of health care to you, or the payment of this health care. We must proved you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new one in the reception area. You can also request a copy of this notice or review it on our website at www.counselingrc.com.

What Information We Collect

As an essential part of our business, we obtain certain personal information about you in order to provide a service to you. Some of the information we receive comes directly from you or on applications or other forms, and may include information you provide during visits to our website or while speaking with our staff. We may also receive information from physicians, schools and other health providers or agencies. The types of information we receive may include addresses, social security number, family information, current and past clinical history and financial information.

Our Privacy Protection Procedures

We protect information about you from unauthorized access. Our employees and agents receive training regarding our privacy policies, and access to information about you is restricted to those individuals that need such information in order to provide services to you. Examples of activities requiring access to personal information include: underwriting, claims processing, reinsurance and policyholder service.

Our Pledge Regarding PHI

We understand that PHI about you and your health is personal. We are committed to protecting PHI about you. We create a record when services are delivered by out professional staff. We need this record to provide you with quality care and to comply with certain legal requirements licensing and accreditation. This notice applies to all of the records of your care generated by the staff.

This notice will tell you about the ways in which we may use and disclose PHI about you. We also describe your rights and certain obligations we have regarding the use and disclosure of PHI. We are required by law to:

1) Make sure that clinical information that identifies you is kept private
2) Give you this notice of our legal duties and privacy practices with respect to clinical information about you
3) Follow the terms of the notice that is currently in effect

HOW WE MAY USE AND DISCLOSE CLINICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We may use and disclose your PHI without your authorization for the following reason.

For Treatment We may use clinical information about you to provide you with clinical treatment or services. We may disclose clinical information about you to doctors, nurses, technicians, or other agency personnel who are involved in providing services to you. Different Counselors may share information about you in order to coordinate services.

For Payment We may use and disclose clinical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company, or a third party resource. For example, we may need to provide information about past or planned treatment to your health plan to obtain authorization or payment for expected and served services.

As Required By Law We will disclose information about the client when required to do so by federal, state or local law. For example, we make disclosures when a law requires that we report information about victims of abuse or neglect.

To Avert a Serious Threat to Health or Safety We may use and disclose client information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent, or lessen the threat.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose client information about you in response to a court order. We may also disclose client information about you in response to a subpoena or other lawful process by someone else involved in the dispute, but only if efforts have been made to protect PHI information.

YOUR RIGHTS REGARDING CLINICAL INFORMATION ABOUT YOU

You have the following rights regarding clinical information we maintain about you:

Right to Inspect and Copy In most cases, you have the right to a copy of your PHI that we have, but you must make the request in writing. To have a copy of your PHI, you must submit your request to your counselor. Fee for the costs of copying, mailing, or other supplies associated with your request.

Right to Amend If you feel that PHI we have about you in incorrect or incomplete, you may ask us to correct or add to the missing information. You have the

right to request an amendment for as long as the information is kept by or for Counseling Resource Center. To request an amendment, your request must be made in writing and submitted to the Custodian of Records. In addition, you must provide a reason that supports your request. We will respond within 60 days of receiving your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we information that:

1. Was not creat6ed by us, unless the person or entity that created the information is no longer available to make the amendment
2. Is not part of the client information kept by or for Counseling Resource Center
3. Is not part of the information which you would be permitted to inspect or copy
4. Is accurate and complete

Our written request will state the reasons for the denial and explain your rights to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your amendment request and our denial be attached to all future disclosures of your PHI> If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others who need to know about the change to your PHI.

Right to an Accounting You have the right to a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already authorized, such as those made directly to you or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or before April 14, 2003.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last 6 years unless you request a shorter time. The list will include the date of the disclosure to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list.

To request this list or accounting of disclosures, you must submit your request in writing to the Custodian of Records. Your request must state a time period which may not be longer than 6 years and may not include dates before April 14, 2003.

Right to Request Restrictions You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or the center's operations. You also have the right to request a limit on the client information we disclose about you to someone who in involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to Custodian of Records. In your request, you must tell us what information you want to limit; whether you want to limit disclosure; and to whom you want the limits to apply.

Right to Request Confidential Communications You have the right to request that we communicate with you about clinical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work rather than at home. To request confidential communications, you must make your request, in writing, to the custodian of Records. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We must agree to your request so long as we can easily provide it in the format you requested.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time or may obtain a copy of this notice at our website, www.counselingrc.com.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised notice effective for client information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the center. The notice will contain the effective date. In addition, when you are a new client a copy of this notice will be included in the intake paperwork.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the center or with the Secretary of the Department of Health and Human Services. To file a complaint with the center, contact Privacy Officer at 281-255-9922. You may also send a written complaint to the Secretary of the Department of Health and Human Services at the following address. All complaints must be submitted in writing.

Director, Office for Civil Rights
US Department of Health and Human Services
200 Independence Ave, SW Room 506-F
Washington D.C., 20201
ocrmail@hhs.gov

You will not be penalized for filing a complaint.

OTHER USES OF CLINICAL INFORMATION

Other uses and disclosures of clinical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose client information about you, or your minor child, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose client information about you or your minor child for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Please note: While the information belongs to you as a client, the record belongs to the Counseling Resource Center. The information will be protected as stated in our Notice of Privacy Practices. We will retain the record under our possession for at least the number of years determined by State and Federal regulatory guidelines. Copies or transfer of the documentation within the record may be subject to a fee.