New Client Information Sheet

Please complete **ALL** questions

Regal Oak Counseling, LLC
PO Box 163781, Fort Worth, TX 76161

1. Client Demographics						
Patient Name: Last:			First:			Middle:
Sex: ( )M ( )F	DOB:	Age:	School Grade:	Marital Status:	Ethnic Origin: ( )Caucasian ( )African-Amer. ( )Amer. Indian ( )Hispanic ( )Asian	
Address:			Apt. #:	City:		State/Zip:
Home Phone: ( )-		Social Security #:		Drivers License #:		State of License:
Employer Name:		Occupation:		Length of Employment:		Employer Phone Number: ( )-
Employer Address:		Suite #:		City:		State/Zip:

2. Emergency Contact			
Name:			
Address:	Apt. #:	City:	State/Zip:
Home Phone: ( )-	Work Phone: ( )-		Relationship:

3. Referral Source
How were you referred to this office? ( )Insurance ( )Hospital ( )Mental Health Professional ( )Other:

4. Previous Counseling		
Last 12 months: ( )Yes ( )No	When:	How Long:
Where:	Why:	If ended, why:

5. Employee Assistance Program Information – if Applicable			
EAP Provider:	Authorization #:	EAP Provider Contact Ph #:	Person Authorized for Benefits:

6. Health Insurance Information				
Insurance Company:	Policy #:		Group Name:	Group #:
Insured's Full Name:	Sex: ( )M ( )F		Relationship:	DOB:
Employer Name:			Employer Phone Number: ( )-	
Employer Address:	Suite #:		City:	State/Zip:

Regal Oak Counseling

Assessment and Counseling Services
1285 N Main St., Ste. 101, Mansfield, TX 76063
(682) 651-7621

CLIENT INFORMATION AND CONSENT

Please READ and INITIAL each section and sign below

Consent to Treatment

_____ I voluntarily agree to receive Mental Health assessment, care, treatment, or services, and authorize Regal Oak Counseling, LLC to provide such care, treatment, or services as are considered necessary and advisable. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification and training of the behavioral health care providers directly supervising the services received by the client.

_____ If the client is under the age of eighteen (18) or unable to consent to treatment, I consent for treatment and/or am legally authorized to initiate and consent to treatment on behalf of this individual. **I also understand if my child no longer resides with both biological parents due to a divorce or change in guardianship, I am required to provide the legal paperwork regarding custody and guardianship information relating to who is able to seek medical/psychological attention, and that this paperwork must be provided before my child can receive counseling services.**

_____ I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services at any time. I understand that the session will not be audio or video taped for any purpose, including educational purposes, by either you or Regal Oak Counseling, without prior written consent.

Appointments

_____ Appointments are made by calling (682) 651-7621. Please call to cancel or reschedule at least 24 hours in advance. **Appointments canceled or rescheduled with less than 24 hours will be charged $35.00, while appointment no calls/no shows will be billed at the full appointment rate.** Exceptions include emergency situations, as well as Military and Public Service Personnel called to duty. I understand missed appointment fees are generally not reimbursed by insurance companies or other third-party payers and will be my responsibility.

Minors/Children

_____ **Children who are receiving counseling services require a parent or guardian to be on premises at all times**. Exceptions may be made ONLY for teenagers who drive themselves to sessions or walk to counseling from the local high school, and require a written statement by the parent, stating they are giving their permission for their teenager's attendance without a parent on premises.

_____ Minor children under the age of 12 years old may not be left unattended and must be accompanied by a parent or guardian while in the building. Regal Oak Counseling does not provide supervision of minor children while parents are in session. Parents who do not have another adult to supervise their children while in session will be asked to reschedule their appointment.

_____ Texas Family Code § 32.003 requires the signature of minors in order to release certain types of information, including mental health records. I understand that any request to release my child's/childrens' mental health records will require my and their signature on the release of information form.

Duration of Counseling

_____The number of sessions needed depends on many factors and will be discussed by the therapist.

Length of Visits

_____Therapy sessions are approximately 45-50 minutes in length.

Professional Relationship

_____You and your therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are appreciated but not allowed by our professional ethics, nor is any trade or service for service (bartering).

Available Services

_____Regal Oak Counseling, LLC offers a wide array of counseling services. These include therapy for individuals, couples, families and groups; assessment; educational assessment and services; career assessment and counseling; and various specialty services. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice and will be pleased to discuss any questions or concerns you may have.

_____The charge for individual in- office sessions is as listed in the fee schedule below, unless there is an agreed-upon rate with your insurance. Different co-payments, co-insurance, and/or deductibles are required by various insurance companies. All fees are due at the time of service. If you have a financial hardship, please speak to our office about financial arrangements. Private pay or out of network services are also due in full at time of service. Regal Oak Counseling can provide you a receipt for submission to your insurance company for reimbursement upon request.

_____***Fee Schedule*** **-** Per Session Rates

Appointment Type	**Intake**			**Each Session After Intake**		
	LPC-Intern	**LPC**	**PhD**	**LPC-Intern**	**LPC**	**PhD**
Individual	125	145	165	100	125	145
Couples/Family	125	145	165	125	145	165
Executive	125	145	165	125	145	165
Discretion/High Profile	125	145	165	125	145	165

*Pro bono counseling may be available with a graduate intern for those who qualify. Ask for more information.

Confidentiality

_____Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist.

Duty to Warn

_____In the event that the therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel.

NAME **RELATIONHIP TO CLIENT** **TELEPHONE NUMBER**

_____

_____

Risks of Therapy

_____Counseling and psychotherapy can be beneficial, but as with any treatment, there are inherent risks. During counseling, you may have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, anxiety, pain, and sadness. Often, growth cannot occur until you experience and confront issues that create obstacles to your health and wellbeing. However, the benefits of counseling can far outweigh any discomfort encountered during the process. Potential benefits include improved personal relationships, reduced feelings of emotional distress, and specific problem solving. While we cannot guarantee these benefits, it is our goal to work with you in a genuinely caring and supporting environment that assists you in accomplishing your therapeutic goals. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy.

Insurance

_____I understand that use of insurance benefits requires a diagnosis. I also understand that any diagnosis/diagnoses are required to be submitted to the insurance company as part of the claim information.

By signing this Client Information and Consent form, I the undersigned client (and/or the parent/guardian if applicable), acknowledge that I have both read and understood all the terms and information contained herein.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian *(if client is under 18 years of age)* Date

_____

Relationship to Client (*if applicable*)

Assignment of Benefits

I authorize all insurance payments to be made to Regal Oak Counseling, LLC. This assignment will remain in effect until revoked by me in writing, I understand this does not relieve me of my obligation to pay any copays or other charges not covered or paid by my insurance company. I understand that I am financially responsible to Regal Oak Counseling, LLC for the charges incurred by myself and/or my dependents.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian *(if client is under 18 years of age)* Date

_____

Relationship to Client (*if applicable)*

Regal Oak Counseling

Acknowledgement of Review of Notice of Privacy Practices

I understand I have a right to review Regal Oak Counseling, LLC Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (referred to as PHI) that will occur in my treatment, payment of my bills, and the rights I have regarding my PHI. I consent to the use or disclosure of my PHI for these purposes.

I understand I have a right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Regal Oak Counseling, LLC is not required to agree to the restrictions that I may request. However, if Regal Oak Counseling, LLC agrees to a restriction that I request, the restriction is binding on Regal Oak Counseling, LLC and my counselor. I also understand that if these restrictions limit the ability of my insurance to pay, I will be held responsible for the entire fee up front.
I understand I have a right to revoke this consent, in writing, at any time, except to the extent that my counselor or Regal Oak Counseling, LLC has already taken action based on this consent.

The Notice of Privacy Practices for Regal Oak Counseling, LLC is provided upon request. Regal Oak Counseling, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

_____

Printed Name of Patient or Parent/Guardian **Patient's Name if Minor**

_____

Signature of Patient or Parent/Guardian **Date**

Communication Authorization

Do we, Regal Oak Counseling, LLC, have permission to:

Leave a message on the phone number provided regarding an appointment? **YES** **NO**

Contact you via text/instant message on your cell phone for appointment reminders? **YES** **NO**

Contact you at work regarding appointment changes, etc? **YES** **NO**

Contact you by email regarding your appointment or bill? **YES** **NO**

Discuss your appointment times with your spouse/parent/partner? **YES** **NO**

Email Address: _____

Send newsletter by email? **YES** **NO**

I acknowledge that confidentiality may not be maintained if text, e-mail or a cell phone is used pertaining to my Protected Health Information.

_____

Printed Name of Patient or Parent/Guardian **Patient's Name if Minor**

_____

Signature of Patient or Parent/Guardian **Date**

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(682) 651-7621

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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the Code of Ethics of the American Association of Christian Counselors and the Texas Counseling Association. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business

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activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the

program (such as third party payors based on your prior consent) and peer reviewed organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official, as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority..

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer at P.O. Box 163781, Fort Worth, Texas 76161-3781

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- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you. We may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this Notice.
- **Electronic Transactions Standards.**

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Carrie Allen, at PO Box 163781, Fort Worth, Texas 76161-3781, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

The effective date of this notice is June 2015.