
**COUPLES & FAMILY THERAPY**
**AND COACHING**
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## GENERAL INFORMATION AND CONSENT FORM FOR THERAPY TREATMENT

Welcome to my therapy services! Thank you for trusting us to assist you with your personal concerns. Please take the time to read and understand this document and ask your therapist about any portions which may be unclear to you.

This document contains important information about our professional services and business policies.

It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices. The accompanying Notice of Privacy Practices explains HIPAA and its application to your PHI in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information before we provide any services. You may revoke this Agreement in writing at any time.

**Policies Regarding Appointments and sessions:**

Individual and couples therapy appointments are generally for 50 minutes and are typically scheduled once per week at a time you and your therapist agree on. That appointment time is a standing time each week, and will be reserved for you until you no longer want it. If you cannot make a scheduled appointment, it is your responsibility to contact the therapist and cancel. If you forget an appointment, call 218-451-3855 as soon as possible to reschedule. If you miss your appointment and do not call to reschedule, your standing appointment time will not be held for you, and there is no guarantee your therapist will have another available appointment time.

**Regarding the therapeutic treatment:**

The therapy treatment involves the expression of your thoughts, feelings, and experiences. You and the therapist will work together to gain the understanding and insight necessary for change to occur. Any goals for therapy and decisions you make to facilitate change are ultimately up to you. Some clients need only a few therapy sessions to achieve their goals; others may require months or even years of treatment.

Therapy can have benefits and *risks*. Since therapy often involves discussing unpleasant aspects of your life, you may experience *uncomfortable feelings*. On the other hand, psychotherapy has also 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.

As a client, you may end the professional relationship at any time without any additional moral, legal, or financial obligation, though I do ask you participate in a *termination session*. At any time, either you or I may initiate discussion of possible positive or negative effects of continuing or not continuing counseling. You have the right to ask any questions about the procedures used during therapy.

Therapist and clients relationship is an exclusively professional relationship rather than a social one. Our contact will be limited to the sessions you arrange with the therapist. In the event of an emergency, you may contact the therapist by phone. Due to ethical guidelines, it is not recommended that you invite the therapist to social gatherings, offer gifts to her, ask her to write references for you, or ask her to relate to you in any way other than the professional context. The therapeutic process will work better if the sessions concentrate exclusively on your concerns. My services will be rendered in a professional manner consistent with accepted ethical standards**.**
**Please note that it is impossible to guarantee you any specific results regarding your treatment goals**. However, the purpose of therapy is to achieve the best possible results for you.

**Regarding audio/video recording of sessions: No recording of sessions is allowed by any party.**

**Minors:**
If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving parents any information we will discuss the matter with you, if possible, and do our best to handle any objections you may have with what we are prepared to discuss.

**Therapy or Coaching with Couples**

It is important to remind couples that any information given to the therapist by one of you may be shared in further sessions with the other member of the couple. At times, there arise instances where one partner in a couple wants to tell me something without the other one knowing it. Please do not expect me to keep secrets where doing so jeopardizes the therapeutic work or my relationship with either of you or your relationship. Please be aware that information you choose to share with me that is particularly pertinent to both of you may come out in therapy. This pertains to all face-to-face, written, and phone conversations and messages.
In case of need to process a complaint about a family therapist in Texas contact:
*Texas Behavioral Health Executive Council*
*George H.W. Bush State Office Building*
*1801 Congress Ave., Ste. 7.300*
*Austin, Texas 78701*
*Main Line (512) 305-7700*
*Investigations/Complaints 24-hour, toll-free system (800) 821-3205*

**By signing below you are stating that you have read and understood this policy statement. In addition, you consent to participate in the therapy treatment.**

**Client's Name:**

Signature of Client/or Parent Date

## CLIENT FINANCIAL CONSENT STATEMENT

• **Fees due when services rendered:** All fees for the therapy services are due before each session unless other arrangements have been made in advance.

• **Court appearances: Please be advised that because my services are provided exclusively virtually, I am not able to attend any Court sessions. Please inform before starting the treatment if you require this services for Court purposes before signing the consent for therapy or coaching.**

•**Letters:** Letters to inform about the treatment will have a cost of $50. Any other document is $50 per page.

• **Fee structure:** Usually fees are increased reasonable once a year during January. If your session fee will be changing, you will be given notice prior to the change taking effect. A fee of $25 for no shows may be charged when not canceling 24 hours prior your session.

**NOTE: After 2 consecutive missed or cancelled appointments your case will be closed.**

**HIPAA and Insurance Companies**

To use your insurance for therapy you will be contacted by **HEADWAY** to add your information such debit/credit card to charge your copay. Remember that some information about your diagnosis and treatment plan may be shared with your health insurance company so they can determine which services are covered. However, the insurance company is required to keep this information confidential, according to HIPAA standards. If you decide to avoid filing an insurance claim and pay out-of-pocket for therapy instead, your insurance company most likely will not be informed of the mental health services you receive.

If your health insurance is through your employer, you can rest assured your employer will not have access to information about the health care services you receive. However, if your company offers an Employee Assistance Program (EAP), it's best to speak with your human resources department about privacy.

https://www.hhs.gov/sites/default/files/hipaa-privacy-rule-and-sharing-info-related-to-mental-health.pdf

**I have read, understand, and agree to the payment information as stated above.**

**Client**

Signature of Client/Responsible Party Date

## 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 IT CAREFULLY.

We are required by The Health Insurance Portability & Accountability Act of 1996 **(HIPAA**) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by Couples & Family Therapy Texas, and of your individual rights and the Center's legal duties with respect to confidential information. **Ways in Which We May Use and Disclose Your Protected Health Information** We may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment, and health care operations.

• **Treatment** means providing, coordinating, or managing mental heath care and related services. *For example* – use or disclosure by the health care provider in training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.

• **Payment** means activities such as obtaining payment for the mental health care services we provide for you either from your insurance or another third party payer. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, and procedures performed.

• **Health care operations** include the business aspects of running our practice. *For example* – to evaluate our treatment and services, or to evaluate our staff's performance while caring for you.

We may contact you to provide appointment reminders or other services that may be of interest to you. We will disclose your protected heath information to any person *you identify* that is involved in your care or payment for your care. *For example* – a family member, relative, close friend, pastor, or pastor's representative with whom you have asked us to communicate. We will use and disclose your protected health information *when required by federal, state, or local law*.

There are certain situations in which as a therapist I am required by ethical standards to reveal information obtained during therapy to other persons or agencies **– *even if you do not give permission***. These situations include:

**(a)** If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies;

**(b)** if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare or social agency which may then investigate the matter;

**(c)** if I am required by a court of law (court order) to turn over to the court or if I am ordered to testify regarding those records.

**(d) If you are requesting disability leave from work and they request copies of your clinical notes, and treatment**

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke an authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. Please sign to indicate you understand our operational use of your information for treatment, payment, and health care operations as stated above.

**Client**

Signature of Client/Responsible Party Date

# Technology Assisted Counseling Consent

This form is in addition to the regular Therapy, Policies, Agreement and Consent Form and Notice of Privacy Practices for Protected Health Information commonly known as HIPAA. You must sign both in order to participate in Technology Assisted Counseling (TAC) sessions. TAC incorporates email, phone and video counseling. Prior to engage in TAC an assessment/consultation will be done to assure that TAC is an appropriate form of counseling. This is to inform you about what you can expect regarding your participation in TAC counseling.

## Benefits

The benefits to TAC counseling are
The ability to expand your choice of service provider.
More convenient counseling options including location, time, no driving, etc.
Reduces the overall cost and time of therapy due to not having to drive to and from and office.
Ability to have real time monitoring and reduces the wait time for scheduling office appointments.

Increased availability of services to homebound clients. clients with limited mobility, and clients without convenient transportation options.

## Limitations

It is important to note that there are limitations to TAC counseling that can affect the quality of the session(s). These limitations include but are not limited to the following
I cannot see you, your body language, or your non-verbal reactions to what we are discussing.
Due to technology limitations I may not hear all of what you are saying and may need to ask you to repeat things.
Technology might fail before or during the TAC counseling session.
Although every effort is made to reduce confidentiality breaches, breaches may occur for various reasons.
To reduce the effect of these limitations, I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.

## Logistics

When I provide phone/video-counseling sessions, I will call you at our scheduled time or send you a link for our secure and HIPAA compliant video session. I expect that you are available at our scheduled time and are prepared, focused and engaged in the session. I am calling you from a private location where I am the only person in the room. You also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where there are people or others can hear you, I cannot be responsible for protecting your confidentiality. Every effort MUST be made on your part to protect your own confidentiality. I suggest you wear a headset to increase confidentiality and also increase the sound quality of our sessions. Please know that I cannot guarantee the privacy or confidentiality of conversations held via phone, as phone conversations can be intercepted either accidentally or intentionally. Please assure you reduce all possibilities of interruptions for the duration of our scheduled appointment.
Please know that per best practices and ethical guidelines I can only practice in the state(s) I am licensed in. That means wherever you reside I must be licensed. You agree to inform me if your therapy location has changed or if you have relocated your domicile to a different jurisdiction.

## Connection Loss During Phone Sessions

If we lose our phone connection during our session, I will call you back immediately. Please also text me at 218-451-3855 if I cannot reach you. If we are unable to reach each other due to technological issues, I will attempt to call you 3 times. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, your phone battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, I will call you from an alternate number. The number may show up as restricted or blocked please be sure to pick it up.

## Connection Loss During Video Sessions

If we lose our connection during a video session, I will call you to troubleshoot the reason we lost connection. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, we can either complete our session via. phone or plan an alternate time to complete the remaining minutes of our session.
Please list your main number and an alternate number below.
Number(s)

## Recording of Sessions

Please note that recording, screenshots, etc. of any kind of any session is **not permitted** and are grounds for termination of the client-therapist relationship.

## Emergencies and Confidentiality

An emergency contact for you is required in your records. Please list the person's first and last name, relationship and phone number(s) of your emergency contact:
**Note: For couples sessions please add an emergency contact other than your spouse/partner**

Emergency Contact First and Last Name:

Relationship to Emergency Contact :

Emergency Contact Phone Number

**I also request the address from which you are calling and the number to your local police department including area code in the area in which you are located during the time of our call.**

Street Address, City, State, Zip

City and State of Local Police Department

Phone Number Of Local Police Department

If a situation occurs where we are talking and get disconnected and you are in crisis, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline at 800-784-2433.
If I have concerns about your safety at any time during a phone session, I will need to break confidentiality and call 911 (if located in the same county or emergency services in the area you are located at the time of the call) and/or your emergency contact immediately. Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.

## Consent to Participate in TAC Sessions

By signing below you agree that you have read and understand all of the above sections of TAC informed consent. You agree that you also understand the limitations associated with participating in TAC counseling sessions and consent to attend sessions under the terms described in this document.

Client's Name

Client Signature

Today's Date

## CLIENT DATA AND CURRENT SYMPTOM CHECKLIST

NAME:

DOB:

ADDRESS:

PHONE NUMBER:

## Medical History

Name of Primary Care Physician

Date of last medical evaluation

Do you consent to contact your PCP or psychiatrist for coordination purposes? (Mandatory question for insurance co.)

☐ Yes ☐ No

If yes, please provide contact information (Name of doctor and phone number)

**ALLERGIES OR SIGNIFICANT MEDICAL CONDITIONS/ MEDICAL DIAGNOSIS**

Please name of allergies or medical conditions you currently have, if any:

## Current Medications

List prescription, dosage, frequency, start date, purpose, and prescriber

Prescriptions

Are you seeing a psychiatrist?

☐ Yes ☐ No

If yes, do you consent on contacting your doctor for coordination of services?

☐ Yes ☐ No

If yes, please provide contact information (Name of doctor and phone number)

Have you taken medication in the past?

☐ Yes ☐ No

List Psychiatric medication currently taking and purpose:

Have you seen a counselor before for mental health concerns?

☐ Yes ☐ No

Who?

When?

Have you been hospitalized for **medical or psychiatric** reasons?

☐ Yes ☐ No

If yes, provide hospital name, date (mo/yr), and reason(s)

Have you been given any **mental health diagnosis** in the past? If yes, please write them down:

If you consent for therapist to contact any other mental health professional you are currently seeing please add name and contact: ☐ Yes ☐ No

If yes, provide name, phone number

Are you participating or receiving help such support groups, social services, school /work based services or any other social support? Please describe:

## ALCOHOL, TOBACCO, AND SUBSTANCE USE

Please disclose any substances you currently or previously used

- ☐ Caffeine
- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuana
- ☐ Heroin
- ☐ Cocaine/Crack
- ☐ Opiates
- ☐ Methamphetamines
- ☐ Inhalants (glue, gas)
- ☐ Stimulants
- ☐ Hallucinogens (LSD)
- ☐ Prescription Drugs
- ☐ Other substances you have used (if applicable)

☐ NONE

Specify age of first use for each substance , amount you are currently consuming

## Mental Status

Have you ever considered suicide in connection with your current problem?

☐ Yes ☐ No

If so, please give a brief description with dates

Have you ever considered suicide in the past?

☐ Yes ☐ No

Have you attempted suicide recently or in the past

☐ Yes ☐ No

If so, please specify with dates

Have you had any homicidal thoughts recently or in regard to your current problem?

☐ Yes ☐ No

If yes, please explain

## Marital History

- ☐ Marital Status
- ☐ Single, never married
- ☐ Engaged
- ☐ Married

How many years?

☐ Divorced
☐ Separated
How long?
☐ Widowed
☐ Living with someone
How many years?
Relationship satisfaction
☐ Very satisfied
☐ Satisfied
☐ Somewhat satisfied
☐ Dissatisfied
☐ Very dissatisfied
Describe any past or current significant issues in intimate relationships

Have you been in any situation where you were abusing another person?

☐ Yes ☐ No
If yes, please explaing:

## Family History

Regarding your family history, please indicate all that apply
Medical Health
☐ Diabetes
☐ Heart Disease
☐ Cancer
Type(s) of cancer
Mental Health
☐ Depression
☐ Anxiety
☐ Mood Swing
☐ If other(s) please specify
Describe any abuse experienced
Other difficult experiences/traumas
(e.g car accident, assault, robbery, etc.

Have you been in any situation where you were abusing another person?

## Describe childhood family experiences

☐ Outstanding home environment
☐ Normal home environment

☐ Chaotic home environment
☐ Alcoholic/addicted parent(s)
☐ Poverty (serious financial problems)

Did you witness any of the following types of abuse?

☐ Does not apply ☐ Physical ☐ Verbal ☐ Sexual abuse

## History

Employment Status, are you

☐ Employed and satisfied ☐ Employed, but dissatisfied ☐ Unemployed ☐ Disabled

If employed, please name your employer and your current position: (**Mandatory question when using insurance)**

Military History
Did you serve in the military?
☐ Never served military ☐ Served in military
Branch
Type of Discharge

## Legal History

☐ No legal problems
☐ Now on parole/probation
☐ Arrest(s) not substance abuse related
☐ Arrest(s) substance abuse related
☐ Going through immigration process
☐ Other history
(Explain in brief detail)

Describe last legal problem

## Social support system

☐ Supportive Network
☐ Few Friends
☐ No Friends
☐ Distant from family of origin

## Other Information

Is there any other information you would like to share with your Therapist that is not covered in this form? Please use the text box below to explain. You can also use this space to complete earlier responses.
Please list your therapy goals and what you expect out of therapy

Client

DATE:

Signature and date

Therapists

| DATE: |
| --- |

Signature and date