MANSFIELD COUNSELING
COUNSELING & ASSESSMENT

Mansfield Counseling Consent for Assessment and Treatment

Client Name _____

I, the undersigned, voluntarily wish to access assessment and treatment counseling services from Mansfield Counseling of Mansfield Texas. I am aware that I am financially responsible for the assessment and treatment counseling unless payment is otherwise assured. I have been informed that any information, knowledge, or records associated with the assessment and treatment are confidential and are subject to release only be my informed, written consent unless otherwise required or permitted by law.

Exceptions to this confidentiality may include

1. **A subpoena or more stringent court order in cases of chemical dependency treatment**
2. **A medical emergency**
3. **Suspected abuse or neglect of any individual e.g. – child or elder abuse**
4. **You are deemed a danger to yourself or others**
5. **Your legal guardians if you are under age 18**
6. **If you have committed a crime on clinic property or toward clinic personnel**

I understand that assessment and treatment may result in a recommendation for treatment or counseling, and that my decision to accept or refuse any recommendation is voluntary.

Furthermore, I understand that Mansfield Counseling associates may determine that further services are not necessary, or that our clinic does not offer services appropriate to your need. In these cases, Mansfield Counseling staff will decline to admit you to our clinic services, and will provide you with referrals to other appropriate providers. By signing below you state that you understand the above information and do grant permission for your minor to participate in assessment and treatment and release the staff members from liability.

By my signature, I acknowledge receiving a full copy of Mansfield Counseling's HIPPA Privacy Policy and Summaries and Disclosures documentation. This policy outlines the duties of Mansfield Counseling and my rights regarding the privacy of all protected Health Information as required by HIPAA (Health Insurance Portability and Accountability Act)

_____

Client Signature Date

In cases of separation or divorce: I have provided legal documentation (divorce decree or current court orders) regarding conservatorship and my legal right to consent to treatment for my child.

_____

Parent(s)/Guardian(s) Signature Date

Contact Information – Parent A (Phone Number, Address, Email)

_____

_____

Contact Information – Parent B (Phone Number, Address, Email)

_____

_____

MANSFIELD COUNSELING
COUNSELING & ASSESSMENT

Mansfield Counseling New Client and Insurance Information

Patient Information
First Name _____Middle ____ Last Name _____
Birth Date _____ Age _____ Sex _____ SS# _____
☐ Married ☐ Single ☐ Other || ☐ Full-Time Student ☐ Part-Time Student ☐ Employed ☐ Unemployed
Home Phone _____ Work Phone _____
Street Address _____
City _____ State _____ Zip _____
Email Address _____
Can you be contacted and a message left at your _____
Employer _____
Employer Address _____

Individual Responsible for Payment
First Name _____Middle ___ Last Name _____
Birth Date _____ Age _____ Sex _____ SS# _____
Home Phone _____ Work Phone _____
Street Address _____
City _____ State _____ Zip _____
Email Address _____
Can you be contacted and a message left at your _____
Employer _____
Employer Address _____

Primary Insurance
Name of Insurance Company _____
Policy ID # _____
Group # _____
Street Address _____
City _____ State _____ Zip _____
Name of Policy Holder _____
Date of Birth _____ Relationship to Insured _____
Employer _____
Employer Address _____

How did you hear about Mansfield Counseling
_____
_____

Assignment of Benefits

I understand that I am responsible for payment in full of all charges. I authorize payment of benefits from my insurance be paid directly to Mansfield Counseling.We must have your cooperation in obtaining necessary information. In the event that payments are not received in a timely manner or there is a collection problem you will be responsible for the insurance portion of your fees. It is your responsibility to notify our office of any changes in insurance coverage, as well as forward any insurance notices to our office. I understand that there is a 24-hour cancelation policy, which requires that I cancel my appointment in advance to avoid the full charge of the session.

_____
Person Responsible for Payment Date

MANSFIELD COUNSELING
COUNSELING & ASSESSMENT

POLICIES AND PROCEDURES – GENERAL COUNSELING

CLIENT CONSENT FOR TREATMENT SERVICES
We are glad that you are here, and are committed to providing you with quality care. Please take a few minutes to read the following information that will explain our office policies and procedures to you. If you have any questions, please ask, and we will be happy to clarify any of the information in this form. Please sign and date the form acknowledging that you have read and fully understood the information and are consenting to begin therapy with us. If you are seeking help for your minor child, please additionally complete, sign and date the Consent for Treatment of a Minor Child form. Please read the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices, and then sign and date the form acknowledging that you have read and understood the HIPAA policies. Finally, please read and sign the attached waiver that details potential risks to your confidentiality. Thank you.

Incapacity or Death: We understand that, in the event of our death or incapacitation, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature on this form, I at this moment consent to Jeffrey S Gallup MA LPC NCC or Linette Morales MA LPC to take possession of my records and provide me with copies at my request, and to deliver those records to another therapist of my choosing.

Qualifications and Services: Your therapists are licensed professional counselors and answerable to the Texas State Board of Examiners of Professional Counselors and his Professional Code of Ethics. During the first few sessions, we will be working toward developing an understanding of your needs and a plan for you and your family. We will direct our mutual efforts toward agreed upon goals determined on an individual basis. Since therapy involves a commitment of your time, energy and finances, you should be sure that you are comfortable working with me. If you decide at any time that we are not a good fit or that other services are needed, I will provide you with appropriate referrals. For therapy to be successful it calls for an active effort on your part and will require you and your family to work on issues and tasks discussed during the session and also at home. While benefits are to be expected from the therapy process, concrete results are not guaranteed, and there are inherent risks.

Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these changes cannot be predicted. Together we will work to achieve the best results for you.

- MENTAL HEALTH & EDUCATIONAL TESTING: We may use objective assessments to aid in treatment planning, diagnostic clarification, and diagnosing learning disabilities in children, adolescents, and adults. Sometimes testing is used to assess progress in treatment, as well as personality and behavior problems. Testing may also be requested in conjunction with legal matters; however, these evaluations are precise in nature and scope and require discussion and review of court documents before Mansfield Counseling formally agreeing to complete the work. Through the use of a variety of standard objective assessments, we will attempt to answer the questions that have brought you for that evaluation. These issues concern learning disabilities, academic functioning, personality functioning, mental health diagnosis or coping styles. Throughout the assessment process, you have the right to inquire about the nature or purpose of all procedures. You also have the right to know the test results, interpretations, and recommendations. The assessment process involves an informational interview followed by the administration of one or more educational and objective evaluations (tests). Although it is sometimes possible to complete the testing procedure in one sitting, it is common for people to be asked to return for another session to finish the assessment battery. Once testing is completed, the data will be analyzed, and a report will be written. You will then have the opportunity to meet with your clinician to discuss the results and receive a copy of the report. It is important to understand that Mansfield Counseling & Jeffrey S Gallup MA LPC NCC does not perform custody evaluations for children, which is a highly specialized field. Also, we do not perform forensic psychological evaluations (to examine and evaluate a patient in anticipation of prosecution or litigation). If you are considering using the results of assessment for a custody dispute or legal purposes, please consult with experts in those areas.

  TYPES OF MEASURES - The type(s) of measures you/your child may receive include:

  - **Cognitive Testing – to assess overall intellectual ability, as well as strengths and weaknesses in verbal comprehension, perceptual reasoning, working memory, and processing speed.**
  - **Memory Testing – to assess overall intellectual ability, as well as strengths and weaknesses in verbal comprehension, perceptual reasoning, working memory, and processing speed.**
  - **Achievement Testing – may be in the areas of word reading, phonics, reading comprehension, written language, math reasoning and calculations, and academic fluency. Measures of oral language may also be obtained.**
  - **Attention and Executive Functioning Testing – to assess attentional processes, along with any difficulties pertaining to initiation, sustained effort, emotional modulation, ability to monitor and self-correct, working memory, organization and planning.**
  - **Diagnostic Interview and Developmental History – to obtain information about the examinee outside of the testing situation, and to obtain a comprehensive history in order to make a more reliable diagnosis.**

- **Behavior Rating Scales and/or on-site behavioral observation at school in order to get a sample of behavior, which occurs outside the office setting.**
- **Social Emotional Assessment – to obtain information of the individual pertaining to psychiatric diagnosis, interpersonal relationships, self-concept, etc.**
- **Interviews with teachers, other family members, physicians, or other relevant individuals (Note: interviews will only be performed with written consent).**

- **PSYCHOTHERAPY:** We provided short-term and long-term counseling designed to address many of the issues with which clients struggle. The first visit will be an assessment session in which you and (your child) and your therapist will determine your concerns, and if both agree, that your therapist can meet your therapeutic needs, a plan of treatment will begin. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. Mansfield Counseling's goal is to provide the most useful therapeutic experience available to you and (your child). If at any time, you feel that you and (your child) and your therapists are not a good fit, please discuss this matter with him to determine if transferring to a more suitable therapist is right for you and (your child). If you and (your child) your therapist decide that services from another provider would be more appropriate, they will assist you and (your child) in finding a clinician to meet your needs.

Confidentiality: We follow the ethical standards prescribed by state and federal law, and my professional governing organizations. Discussions between us are confidential, and you have the right to a confidential relationship with me. I am required by practice guidelines and standards of care to keep records of your counseling or therapy. All of our communication becomes part of yours or your family's clinical history. These files are confidential according to certain legal and ethical limits and clinical parameters, and the HIPAA Notice of Privacy Practices provided to you. Within these limits, the information revealed by you during therapy will be kept confidential. No information will be released without your written consent and authorization unless mandated by law. Possible legal exceptions to confidentiality include, but are not limited to, the following situations:

- If you reveal information that indicates you is a danger to yourself or someone else necessitating a duty to protect or duty to warn.
- If you reveal information about child abuse, neglect, elder abuse or sexual exploitation.
- If you are in therapy as the result of a court order, unless otherwise stated in the court order.
- If I receive a subpoena or a court order to disclose information.
- If you provide written permission or direction to release your record.

Duty to Warn/Duty to Protect: If your therapist believes that I (or my child if my child is the client) am is in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my therapist to contact any person who is in a position to prevent harm to another, or me including, but not limited to, the person in danger. By signing this Information and Consent form, you are giving consent for me to share confidential information with all persons mandated by law or for whom you have provided written permission, and you are releasing and holding Mansfield Counseling staff and clinicians harmless for any departure from your right to confidentiality that may result. If you have any questions or concerns regarding confidentiality, please discuss them with us before signing this form.

Minors and Parents: Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. However, if the treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse, the law provides that parents may not access their child's records. For children, privacy in psychotherapy is often crucial to successful progress, particularly with teenagers. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have. Treatment of minors under the age of 18 will only be provided with the permission of the legal guardian or conservator. **By signing this form for a minor client, you state that you are the legal guardian or conservator of the minor client with the legal right to consent to treatment and you agree to provide a copy of current divorce/child custody order if any exists. This agency must have a copy of the current order to begin treatment.**

Payment: All appointments are generally 45-50 minutes and are billed on a per session basis. Payment is due at the time services are rendered. Sessions may be scheduled for a longer period of time and in such instances are billed on a prorated basis. If you call to cancel your scheduled appointment at least 24 hours (48 hours for testing) in advance you will not be charged. If you provide less than 24 hours (48 hours for testing) notice, there will be a full-fee charge, some emergency situations notwithstanding. Each such circumstance shall be evaluated and a determination as to the charge will be made at that time solely by your therapist.

Court Ordered Therapy: If a court has ordered you or your family's therapy, there are further limitations imposed on your rights as a client. These may include the decision to delineate the number of sessions available to you or require your participation at a specified frequency. Under these circumstances, a report of your attendance and your progress in therapy may be necessary. I do not have control over any aspect of the rules or stipulation made by the court but will take steps to protect your privacy to the extent possible. In some cases, clients are court ordered to therapy. Although you may be providing payment to Mansfield Counseling, this agency is working under court appointment, and the staff or your counselor may be required by the court to provide information regarding services rendered per the court order. During court ordered counseling this agency or your therapist may also be required to provide information to one or more of the attorneys involved.

Appointments: Services are by appointment only. You are responsible for keeping your appointment and arriving on time. If you cannot keep an appointment, it is your responsibility to call the office at least 24 hours in advance to cancel or reschedule. Please help us serve you better by

being responsible for keeping your scheduled appointments. The telephone is answered either by the office manager or voice mail so that messages can be left 24 hours a day, seven days a week. Due to our appointment schedule, it may be several hours before we can return your call. Calls received late in the day may not be returned until the following day. After- hours or weekend calls and emails are not returned until the next day or the following Monday as I do not check either voicemail or email after work hours or on the weekend.

Emergencies: You may encounter a personal emergency that may require prompt attention. Please contact our office, and we will make reasonable efforts to respond to your emergency promptly. If it is after hours or on the weekend, or you reach the office voice mail during an emergency situation, please go to the nearest emergency room and ask for assistance regarding a mental health emergency, or call 911. When we are out of town, we will provide the name and contact information for an on-call therapist.
We may utilize unencrypted email as a means of communication on a limited basis, but we will not engage in therapy over the Internet. Any audio/visual recording is prohibited in therapy sessions, without prior discussion and our consent.

If you are seeking treatment as a function of a court order, I require a hard copy of the court order. If you are seeking treatment for your child and are divorced, separated, or currently involved in any legal proceedings, you must submit a hard copy of your divorce decree and any additional orders currently in effect that supplement the decree. In so doing, you are documenting that you have the legal right to seek treatment for your child.

Termination of Therapy: Therapy is not mandatory unless you are in treatment as a function of a court order. Unless it is court ordered, you may choose to leave counseling at any time, but this decision is best accomplished in consultation with me. You have the right to discuss positive or adverse effects of counseling with me. Our goal is to provide services to you in a professional and ethical manner. If you are dissatisfied for any reason, please discuss your concerns with us.

EFFECTIVE DATE: Wednesday, January 16, 19

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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION
Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS
Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:
1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information**. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:

- Was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
- Is not part of your medical or billing records;
- Is not available for inspection as set forth above; or
- Is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:

- To carry out treatment, payment and health care operations as provided above;
- To persons involved in your care or for other notification purposes as provided by law;
- To correctional institutions or law enforcement officials as provided by law;
- For national security or intelligence purposes;
- That occurred prior to the date of compliance with privacy standards (April 14, 2003);
- Incidental to other permissible uses or disclosures;
- That are part of a limited data set (does not contain protected health information that directly
- Identifies individuals);

- Made to patient or their personal representatives;
- For which a written authorization form from the patient has been received

7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured PHI This organization may use and/or disclose your medical information for the following purposes:**

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one healthcare provider to another.
Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.
Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.
Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.
Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you
Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.
Individuals Involved in Your Care or Payment for Your Care:
Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.
Business Associates: There may be some services provided in our organization through contracts with Business Associates.
Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.
Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.
Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.
Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena.
For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.
Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.
Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order.
We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.
Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.
Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.
Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.
Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.
Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
Research (inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Waiver of Business Practices: The following business practices, though not all-inclusive, may constitute a potential risk to your confidentiality, in spite of the security measures that we have in place to protect your privacy. By signing below you understand and acknowledge the possible risk and your consent for such practices to be utilized. Use of an electronic calendar, Use of a paper calendar, Use of a cell phone for communication with you and other professionals, Use of a laptop computer, Use of unencrypted email, Use of computerized billing, Use of shared office space with the independent practices of other mental health, Professionals with potential access to, among other things, common storage, File space, mailboxes, voicemail, and messages, fax machine and faxes, Use of shared administrative staff

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site. Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (I) most uses and disclosures of psychotherapy notes (ii) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of your health information; and (iv) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer Jeffrey S Gallup MA LPC-S NCC, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer Jeffrey S Gallup MA LPC-S NCC or with the Secretary of the Department of Health and Human Services or Texas Attorney General's office. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints. The contact information for both is included below.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

Texas State Board of Examiners of Professional Counselors
Texas Department of State Health Services
Mail Code 1982
P.O. Box 149347
Austin, Texas 78714-9347E-mail: lpc@dshs.state.tx.us
Telephone: (512) 834-6658
Fax: (512) 834-6677