HeartLife Counseling

Main Phone#: 214.641.6697 Main Fax#: 214.513.7800
www.heartlifecounseling.com

Client Information

Office Location: _____ **DX:** _____

Appointment Date:_____ **Counselor:**_____

Client's Name: _____
First Middle Initial Last

Address: _____
City:_____ State: _____ Zip: _____

Social Security #: _____ Date of Birth: _____ Email:_____

Phone: (_____)_____ (_____)_____ (____)_____
Home Work Cell

Spouse /Guardian/Parent Information (please circle one):

Name:_____
First Middle Initial Last

Address (if different from client): _____

Social Security #_____ Date of Birth_____ Email: _____

Phone: (_____)_____ (_____)_____ (____)_____
Home Work Cell

Other Information: **Dependents**: _____
Name Relation DOB

_____
Name Relation DOB

_____
Name Relation DOB

Church Affiliation: _____ Referred by: _____

Insurance Information

(Note: Please present insurance card with this form to be photocopied. Thank you.)

Name of Insured: _____**SSN:** _____

Insured's DOB: _____ **ID#:** _____ **Group#:** _____

Insurance Carrier: _____

Address: _____

CITY:_____**ST:** _____**ZIP:** _____

Benefit/Eligibility Phone Number: (____)_____ **Deductible:**_____

Insured's Employer: _____

Address: _____

City: _____**ST:** _____**ZIP:** _____ **Phone:** _____

I authorize the release of any medical or other information necessary to process this claim.

_____
Insured's or Authorized Person's Signature

I authorize payment of medical benefits to the provider of services. I understand that I am responsible for my bill, not my insurance company. I am aware that if my insurance company declines payment, I am responsible for my bill.

_____
Insured's or Authorized Person's Signature

HeartLife Counseling

Welcome to **HeartLife Counseling**! It is our deepest desire to help you with whatever problem has brought you here. Our hope is to compassionately handle your struggle with grace and kindness and help guide you to where you need to be. Together we will work towards that solution as a team. **HeartLife Counseling** is dedicated to guiding individuals to a greater understanding of themselves as well as the world around them. For **HeartLife Counseling**, this is done in a holistic manner where counseling can include issues surrounding thoughts, feelings, actions, and beliefs. It is important to understand that counseling can only work if you are willing to open up every area of your life for self-examination. This can be a slow process if necessary, but it doesn't have to be. **HeartLife Counseling** is goal oriented and directive. We are dedicated to being an objective third party that will guide you towards looking at your circumstances from multiple perspectives and points of view. This intensive level of counseling can be difficult, but it is definitely worth it.

Confidentiality: Everything spoken here at **HeartLife** is protected by the confidentiality statutes of the State of Texas. That means **HeartLife Counseling** will in no way disclose any information without your written consent except in the following situations: (a) If you threaten grave bodily harm or death to yourself or another person, your counselor is required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to your counselor your knowledge of the physical or sexual abuse of a minor child by an adult or of an elder (over 65) by an adult, your counselor is required by law to inform the appropriate child welfare agency which may then investigate the matter; (c) if your counselor is required by a court of law (court order) to turn over records to the court or is ordered to testify regarding those records.

Supervision: **HeartLife Counseling** operates as a team to improve the quality of counseling. Your session may be discussed with your counselor's colleagues, but only with your permission.

Appointments: Counseling sessions are 45-50 minutes. For counseling to be effective several things are required: commitment to the process through faithfully attending appointments; completing "homework assignments" between sessions; establishing clearly defined goals (the counselor will help do this in the first session); and a willingness to accept the truth. **HeartLife Counseling** requires that 24 hours notice be given if canceling an appointment becomes necessary. You will be billed for the session if less than 24 hours notice is given; emergency situations may be discussed with your counselor.

Financial Policy: The standard fee for services provided by **HeartLife Counseling** is $135.00 for the initial session and $125.00 per session thereafter. Payment is due when counseling services are rendered, at the end of the session. **HeartLife** does participate in some managed care agreements with insurance companies. **HeartLife** will agree to file insurance claims on an in-network basis where applicable or on an out-of-network basis with mental health benefits if the client has applicable insurance coverage. The client is responsible for any co-payments, deductibles, and non-allowed charges. It is the client's responsibility to know what their insurance policy covers and to make sure the deductible is met. The issue of fee and reimbursement will be discussed and determined by the client and counselor during the first session. **HeartLife Counseling** will provide an invoice to the client at each session.

Please let your Counselor know if you have any questions.

If client is under 18, I _____ (please print), have legal custody and give my consent for counseling of the above named minor. If client is a child/children of divorce, **HeartLife Counseling** will need a copy of the divorce decree showing the legal custodian of the child/children.

_____
Signature of Parent or Guardian

All members of your family who are involved in counseling need to sign below, indicating understanding of these policies and procedures.

ACKNOWLEDGED:

Date: _____ Clients Signatures: _____

_____

Date: _____ Counselor Signature: _____

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NOTICE OF PRIVACY PRACTICES *(Client's copy)*

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make a new Notice available upon request.

USES & DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

1. **We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes. To help clarify these terms, here are some definitions:**
    - **"*PHI*" refers to information in your health record that could identify you.**
    - **"*Treatment, Payment, and Health Care Operations*"**
        - ***Treatment* is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician, or other practitioner.**
        - ***Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.**
        - ***Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business related matters, such as audits and administrative services, and case management and care coordination.**
    - **"*Use*" applies only to activities within HeartLife Counseling, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.**
    - **"*Disclosure*" applies to activities outside of HeartLife Counseling, such as releasing, transferring, or providing access to information about you to other parties.**
2. **We may disclose to a family member, other relative, a close personal friend of yours, or any other person identified by you, the health information directly relevant to such a person's involvement with your care or payment related to your health care.**

USES AND DISCLOSURES REQUIRING AUTHORIZATION

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission that is above and beyond the general consent that permits only specific disclosures. In those instances, when we are asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your counseling notes. "*Counseling notes*" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or counseling notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

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UESES AND DISCOLSURES WITH NEITHER CONSENT NOR AUTHRIZAITON

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Texas Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against us with the State Board of Examiners, the board has the authority to subpoena confidential mental health information from us relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof , such information is privileged under state law, and we will not release information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

PATIENT RIGHTS

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described previously). On your request, we will discuss with you the details of the accounting process.

QUESTIONS OR COMPLAINTS

For more information about our privacy policy or have questions or concerns, please contact us. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may complain to us using the contact information listed at the end of this Notice. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will provide you with that address to file your complaint upon request.

Contact Officer: Chris Dockins
Telephone: 214-641-6697
Address: 6021 Morriss Road, Suite 106
Flower Mound, TX 75028

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempt to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgment**
- ☐ **An emergency situation prevented us from obtaining acknowledgment**
- ☐ **Other (specify below)**

_____
_____
_____

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Credit Card Consent Form

I, _____, give my expressed permission for any session fees incurred by the following person(s) _____ to be charged to my credit card (information below) for the HeartLife Counselor, _____ (Counselor's name).

Credit Card Information

Name: _____ (As it appears on card)

Card Type: _____

Card Number: _____

SEC Code: _____

Expiration Date: _____

Billing Zip Code: _____

_____

Signature of the Credit Card Holder