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INTAKE FORM

Please fill out the following to the best of your knowledge. Once completed, your counselor will meet with you to discuss the information and review counseling services and CareFully's policies.

Information

Name: _____ D.O.B.:_____ Gender Identity: _____

Spouse/partner: No ❒ Yes ❒ (**complete section below**) Child(ren) from a previous relationship: No ❒ Yes ❒

Employer:_____ Occupation: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Home Address: _____ City: _____

State: _____ Zip: _____ SSN: _____-_____-_____

Name: _____ D.O.B.:_____ Gender Identity: _____

Child(ren) from a previous relationship: No ❒ Yes ❒

Employer:_____ Occupation: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Home Address: _____ City: _____

State: _____ Zip: _____ SSN: _____-_____-_____

Are there other adults residing at the family home? No❒ Yes❒ **(please complete the section below if yes)**

Name: _____ D.O.B.:_____ Gender Identity: _____

Relationship to family: _____

Name: _____ D.O.B.:_____ Gender Identity: _____

Relationship to family: _____

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Names of Children at Home	*Age*	*DOB*	*Additional Notes*

Names of Children NOT at Home	*Age*	*DOB*	*Additional Notes*

If you could change anything about your relationship with your partner or family, what would it be?

Briefly describe any special situations, e.g. divorce, loss of job or relationship, custody issues, adoption, foster care, ongoing CPS involvement, loss of a loved one, etc.

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

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Reason for Visit

Please share why you are considering counseling:

_____

_____

What are your goals and hopes for the counseling process?

_____

_____

How did you hear about CareFully?

_____

_____

Spiritual and Cultural

Is there anything you feel is important for us to know about your culture, spirituality or religion? Please explain:

_____

_____

Is there a family history of…	Yes	No	Who?
Drug Use			
Alcohol Abuse			
Depression			
Bipolar			
Schizophrenia			
ADHD			
Sensory Integration Disorder			
Other Mental Health Concerns			

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Stressors

Before completing the following section regarding stressors, please be advised that all personnel employed by CareFully are obligated to report suspicions of abuse of a child, abuse of an individual who is age 65 or older, or abuse of an individual who is differently abled to Child Protective Services or Adult Protective Services as mandated by Texas law. Please review the attached confidentiality policy for more information.

Below is a list of stressors that you or your children may have experienced. Please check all that apply, or leave blank if you choose not to answer.

	No	Yes	If Yes, Please Explain
Grief Over Loss Or Death			
Separation / Divorce			
Marital Conflict			
Family / Domestic Violence			
Moving (Home, Work, School)			
Financial Stress			
Out Of Home Placement Of A Child			
Change Of Primary Caregiver			
Serious Injury Or Medical Illness			
Arrest Or Incarceration			
Crime Victim			
Natural Disaster			
Deportation Of Significant Other			
Other Trauma Or Stressor			

Closing

Is there anything else that you feel is important to know that has not been covered? Do you have any questions or concerns?

_____

_____

Client signature _____ Date _____

Intake staff signature_____ Date _____

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PROFESSIONAL DISCLOSURE STATEMENT

Amber Worner , M.Ed., LPC, RPT
LPC License # 69495
CareFully, PLLC
23120 State Hwy 71W. Spicewood, TX 78669
(512) 994-0363 www.CareFullyCounseling.com

Qualifications
I am a graduate of Sul Ross State University with a master's degree in education, specializing in school counseling. My postgraduate coursework meets all the qualifications to sit for the NCE (National Counselors Examination) and become a Licensed Professional Counselor in the state of Texas. I am qualified to provide services to individuals, couples, families, parents, children, adolescents and groups. I am a Licensed Professional Counselor and a trained Play Therapist.

Nature of Counseling
I practice counseling with a positive view of human nature and with a belief that meaningful change is possible through a collaborative therapeutic process. As part of that collaboration, we will review your previous relationships, interactions, choices and patterns of past behavior to help set new, satisfying and attainable goals for the future. These goals may relate to any area of life that is important to you. In marital, couple and family therapy, sessions will focus on addressing conflicts and stressors, developing constructive communication, expressing and fulfilling needs, and strengthening the resiliency of your relationships.

Some clients need only a few counseling sessions to achieve their goals, while others may require more. As a client, you have the right to end our counseling relationship at any time. Should you choose to end our relationship, I only ask that you return for one final termination session. You also have the right to refuse or negotiate modification(s) of any of my suggestions that you believe might be harmful. At any time, either you or I may initiate discussion of possible positive or negative effects of entering or not entering counseling, continuing or not continuing counseling, and/or using or not using certain techniques presented by me.

Sessions are held weekly for 50 minutes for individuals and 60 minutes for couples/families. Although our sessions may be very intimate psychologically, ours is a professional relationship. Please limit our contact to counseling sessions you arrange with me, except in the case of an emergency. **In the case of an emergency, please call 911 or go to the nearest emergency room.** Please do not invite me to social gatherings, offer me gifts, ask me to write a reference for you, or ask me to spend time with you in any other way than the professional context of our counseling sessions. Also, you will be best served if our sessions concentrate exclusively on your concerns, rather than on my thoughts or experiences. Although you may learn a great deal about me as we work together during your counseling experience, it is important for you to remember that you are experiencing me in my professional role only.

In the event you wish to make a complaint regarding services you receive at CareFully, then please contact the Texas Department of State Health Services using the following information:

Complaints Management and Investigative Section P.O. Box 141369
Austin, Texas 78714-1369
1-800-942-5540

https://www.dshs.state.tx.us/mft/mft_complaint.shtm

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FEES, PAYMENT & ATTENDANCE POLICY

Fees

The fees at CareFully are as follows:

- Individual - $175 per 45-55 minute session
- Individual - $260 per 90 minute session
- Parent Coaching - $175 per 45-55 minute session
- Group - $85 per person per 60-90 minute session
- Intake - $275 per 60-90 minute session (this is the initial session)

School Meetings

- $175 per hour, rounded to the nearest one-quarter of an hour for any communication with school personnel. This includes travel time to and from the school for in-person meetings.

Court Fees

In the event that a counselor at CareFully is asked to testify in a court case on behalf of a client, then the following fees shall apply:

- $500 per hour, rounded up to the nearest one-quarter of an hour, for any activities associated with the court appearance, including, but not limited to: research; reviewing materials; drafting/reading emails, letters and documents; consultations and conferences, either in person or via telephone with the client and/or client's lawyer on any matter pertaining to the court appearance; file copying; file preparation; travel time and time spent in court (including time waiting).
- Client will be responsible for all costs, including but not limited to: travel expenses, parking costs and any associated court costs.

Please note that payment is due prior to the start of each session. For court fees, payment is due upon receipt of the invoice for those fees.

Attendance Policy

Making changes through counseling can be difficult and depends on many things, one of which is attendance. Being present and prepared to actively participate in each session will increase the likelihood of making the changes you wish to see.

Client responsibility: If you need to cancel your scheduled counseling appointment for any reason, please contact us at least 24 hours before your scheduled appointment begins. **Any appointment cancelled within 24 hours of the scheduled time for that appointment shall be billed at the full session rate.** If you are late to an appointment for any reason, please be aware your session will still end as scheduled and will not extend past the scheduled ending time. Payment for the full scheduled session will be charged.

Counselor responsibility: If your counselor needs to cancel, every effort will be made to contact you as soon as possible before your scheduled appointment begins. Please keep in mind we will contact you at the phone number provided to us; if your contact information changes, please notify us as soon as possible. Due to the nature of counseling sessions may occasionally run longer than scheduled. In the event this happens please understand that the counselor will extend the same courtesy to you if the need arises. **All sessions that extend past the scheduled time will be rounded up and charged at the rate of $43.75 per quarter hour.**

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Please sign below to indicate you have had an opportunity to ask questions about the fees, payment and attendance policy and that you understand them as explained to you.

_____	_____	_____	_____
Client Signature	Date	Counselor Signature	Date

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CONSENT TO PROVIDE EVALUATION AND/OR TREATMENT

CareFully provides evaluation and counseling services to clients wishing to receive such services. Our services include, but are not limited to, pre- and post-treatment evaluations; individual, family, and group counseling; and play therapy. We use evaluations so that we might better understand and measure the effectiveness of counseling programs, and we use a variety of treatment programs to help individuals move toward the changes they wish to see in themselves and their families.

I, _____(child's parent/guardian) consent to the following for my

child _____(child's name):

_____ Participation in pre- and post-evaluations

_____ Participation in treatment (counseling)

Please note, the success of the counseling process will depend on your active involvement as the child's parent or guardian to make the changes your counselor may recommend.

If you have any questions at any time about the evaluation and treatment programs used at CareFully, please do not hesitate to ask your counselor.

By signing below, you are signifying that you consent to treatment. You are choosing to be an active, supportive part of the counseling process. You may withdraw your consent at any time.

_____ _____

Parent / Guardian Name (printed) Date

_____ _____

Parent / Guardian Name (printed) Relationship To Child

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 about you that may identify you and that 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 *ACA Code of Ethics*. 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 and 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, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business 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 disclose 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.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a Licensed Professional Counselor, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *American Counseling Association's Code of Ethics* and HIPAA.

Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect towards children, the elderly, and people with disabilities.

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 payers based on your prior consent) and peer review 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 your 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.

Verbal Permission. We may also 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 at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to CareFully at 600 Avenue J, Marble Falls, Texas, 78654.

- **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 is maintained in a “designated record set." A designated record set contains mental health/medical and billing records and any other records that are 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 or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **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. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **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 unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will

accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- **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.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with CareFully at 23120 State Hwy. 71W., Spicewood TX 78669, 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 September 2015.

carefully

NOTICE OF PRIVACY PRACTICES RECEIPT & ACKNOWLEDGMENT

Name:_____

Date of Birth**:** _____

Social Security Number: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of CareFully's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact CareFully at 23120 State Hwy 71W. Spicewood, TX 78669 or call (512) 994-0363.

_____ _____

Signature **Date**

_____

Print Name

❒ A good faith attempt was made by CareFully staff to provide “Notice of Privacy Practices.” However, client refuses to acknowledge receipt of “Notice of Privacy Practices” due to:

_____ _____

Signature of Staff Member **Date**

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ELECTRONICS & RECORDING POLICY

- It is important for you to be aware that computers, email, text, and other forms of electronic communication are potentially accessible by unauthorized individuals or organizations, which can compromise the privacy and confidentiality of information being stored or transmitted. Emails, texts, and all other forms of electronic communications are vulnerable to such unauthorized access owing to the fact that communication companies may have unlimited and direct access to all electronic communications that pass through their servers. While data and emails sent from a CareFully email address, and data on CareFully computers is encrypted, CareFully cannot guarantee the security of such communication once it leaves the CareFully domain.

- CareFully computers are equipped with a firewall, virus protection and passwords, and all confidential information is backed up on a regular basis to an encrypted hard-drive or server. CareFully emails are also encrypted per HIPAA standards.

- The text policy at CareFully is that text messages are only to be used to confirm or cancel appointment times. Please call if additional communication is needed.

- Please be advised that CareFully makes every effort to respond to emails and telephone calls within 24 hours during normal business hours/days with the exception of holidays or when CareFully offices are closed.

- Please do not use texts, email, voice mail, or faxes for emergencies. **In the event of an emergency, please call 911 or proceed directly to your nearest emergency room or hospital.**

- Please notify your therapist at CareFully if you would like to avoid or limit, in any way, the use of email, texts, cell phone calls, phone messages, or e-faxes for communications with your therapist. Please also note that you, as the client, accept all liability and risk if you choose to communicate confidential or private information electronically in any form and by signing this policy, you are indicating that you have read and accept this policy. Do not hesitate to let your therapist know if you have any questions regarding this communications policy.

- **All audio and/or video recording of conversations, consultations, telephone calls or counseling sessions involving CareFully personnel is strictly forbidden without the express written consent of the individual counselor being recorded.**

_____ _____

Signature Date

_____ _____

Signature Date

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CONFIDENTIALITY POLICY

Your confidentiality is extremely important to us. We will not disclose any of your information, including your status as a client at CareFully, to anyone who is not an employee of CareFully or an approved supervisor for CareFully, without your written consent, with the exception of the following:

- If there is suspicion of abuse to a child, individual who is age 65 or older, or an individual who is differently abled, we will report our suspicions to Child Protective Services or Adult Protective Services as mandated by Texas law.
- If an individual wishes to harm himself or herself or another individual, we reserve the right to break confidentiality in order to seek help and protection for the individual and others.
- If client records are subpoenaed by a court of law, we are required to release these records as detailed in the subpoena.

Please keep in mind that your confidentiality extends beyond CareFully. Because we live in ` the same community, it is possible you may see an employee of CareFully outside of our office, such as at a restaurant or shopping center. To protect your confidentiality and privacy, employees will not acknowledge or approach you outside of CareFully. If you wish to initiate contact by approaching or acknowledging an employee, you are welcome to do so.

_____ _____

Signature Date

_____ _____

Signature Date

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CLIENT BILL OF RIGHTS

As a client of CareFully, you are entitled to the following rights:

1. You have the right to be treated with consideration and respect at all times, regardless of age, race, ethnicity, sexual orientation or identity, disability, or socioeconomic status.

2. You have the right to share your thoughts and feelings without fear of judgment or harassment.

3. You have the right to ask questions and receive information in an understandable format about any services you receive.

4. You have the right to view the information kept in your files. When viewing such information is not advisable, we request a preliminary discussion before releasing your files.

5. You have the right to refuse any and all treatment to the extent permitted by law and to be informed of any consequences of such treatment.

6. You have the right to expect confidentiality and privacy concerning your status and participation at CareFully; this confidentiality is limited only by those exceptions listed in the “Confidentiality Policy.”

7. You have the right to be advised if an employee at CareFully proposes to conduct research, which might affect your care or treatment. You have the right to refuse to participate in such research projects.

If you have any questions at any time about your rights while participating in services at CareFully, please do not hesitate to ask your counselor. If you feel your rights have been violated, we encourage you to discuss your concerns with your counselor or other employee of CareFully.

Name (printed) / Relationship to Child (if applicable)	Date
Signature	Child Client’s Name (if applicable)

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Credit Card Authorization Form

Name on Card: _____

Type of Card: Visa ☐ MC ☐ AmEx ☐ Discover ☐

Last 4 Digits of Account Number _____

Expiration Date _____

Security Code _____

Billing Address _____

City, State, Zip _____

Phone Number _____

By signing this form, you authorize CareFully Counseling, PLLC to charge the credit card on file on a reoccurring basis for therapy appointments attended, and no show/late cancel appointments.

Signed: _____ **Date:** _____