SOUTHEAST TEXAS CHRISTIAN COUNSELING CENTER

3739 NORTH MAJOR DRIVE
BEAUMONT, TEXAS 77713
409.833.6747
Larry Walker, MED, LPC, AAIM*, BCPC*, CRS, CART
***American Association of Integrative Medicine**
****American Psychotherapy Association**

Date: _____
Name:_____ Birth Date: _____
Address: _____ City: _____ ZIP _____
Phone: H _____ C: _____ E-Mail: _____
(Is it alright to leave a message? Yes____ No____)

Social Security Number: _____

CANCELLATION POLICY: The Counseling Center is a "Fee for Service" mental health provider. If you fail to cancel a scheduled appointment, a full session fee is charged for missed appointments or cancellations with less than a 24 hour notice unless it is due to illness or an emergency. Thank you for understanding this important matter. Please acknowledge you have read and agree to this policy._____

Payment: Cash_____ Credit/Debit Card (Provide information)_____

CC/DC info: Name on Card _____
Card No. _____ _____ _____ _____ Exp. Date ____/____
CV (back of card) ____ ZIP Code_____

Insurance: We will be happy to provide you a copy of this form as support for you to file on your insurance. Please check with your insurance provider to verify coverage for counseling services

Payment for counseling services is due at the time of your appointment and is your responsibility.

Diagnosis Code: ICD 10 CM _____

Dates of visits/CPT Codes, Required Modifiers-(HO), Allowable POS-(03-08)

_____ 90791 Psychiatric diagnosis evaluation
_____ 90832 Psychotherapy, 30 minutes with patient and/or family member
_____ 90834 Psychotherapy, 45 minutes with patient and/or family member
_____ 90837 Psychotherapy, 60 minutes with patient and/or family member
_____ 90839 Psychotherapy for crisis; first 60 minutes
_____ 90840 Psychotherapy for crisis each additional 30 minutes
_____ 90845 Psychoanalysis
_____ 90846 Family psychotherapy (without the patient present) Is not couples therapy.
_____ 90847 Family psychotherapy (conjoint, with patient present) Is not couples therapy.
_____ 90899 Unlisted psychiatric service or procedure
_____ Couples Therapy Medically necessary (Requires ICD 10 diagnosis for one person/patient)

Personal Information Form (confidential)

The information asked for below is to help us understand you and your concerns. Please fill out this form as completely as you can. All information will be held in strict confidence.

Date: _____ SSN#: _____

Name: Mr.
Mrs.
Ms. _____
First Middle Last

Address: _____

_____ ZIP _____

Telephone: (Home) _____ (Work) _____

Employer: _____ Monthly Income: $_____

If student, which school do you attend? _____

Age:_____ Sex:_____ DOB:_____ Physician:_____

Marital Status: Married _____ Single _____
Widow_____ Divorced_____ Separated_____

Guardian/Parents (if under 18):_____

Religious Pref: _____ Church you attend:_____

Responsible for Payment? Self____ Family____ Other____

Date of Present Marriage:

_____

Name of Spouse: _____

Have you ever been divorced? _____

Names and ages of children in order of birth:

Name	Age	Sex

Have any children died? Yes_____ No_____

Education: (Indicate last grade completed – last degree earned)

_____

Military Service:_____ Dates: _____

Did you serve in combat? Yes _____ No _____

Family Background:

Father: Name _____ Living? _____ Deceased? _____

Mother: Name_____ Living? _____ Deceased? _____

Brothers and Sisters in order of birth:

Name	Age	Sex	Deceased (Date)

Did members of your family of origin suffer from Depression, Ulcers, Alcohol problems, Drugs Abuse, Asthma, Chronic Headaches, High Blood Pressure, Colitis, Etc.? Describe: _____

_____

_____

Medical Information:

Have you had Previous Counseling? _____ When _____

With Whom? _____

Are you presently seeing another Therapist? _____

Are you presently on medication? _____ If so, what medication? _____

For what condition(s)? _____

Prescribed by? _____

What do you believe your Physical Condition is at the present time?

Poor Fair Average Good Excellent (Circle One)

Have you had a Physical Exam in the last three years? YES NO

What do you believe your Emotional Condition is presently?

Poor Fair Average Good Excellent (Circle one)

Concerns: State in your own words the concerns you bring to counseling:

_____

_____

_____

_____

_____

Check the items that describe or relate to the concerns mentioned above:

____ Anxiety
____ Bereavement
____ Depression
____ Nervousness
____ Loneliness
____ Marriage Problems
____ Sexual Concerns
____ Impotency
____ Frigidity
____ Homosexuality
____ Fear
____ Self Doubt
____ Guilt
____ Suicidal Feelings
____ Relationships with Parents
____ Relationship with Children
____ Religious Doubts
____ Loss of Faith/God
____ Loss of Faith/Self
____ Loss of Faith/Others
____ Loss of Hope
____ Loss of Meaning
____ Loss of Self-Respect
____ Loss of Love

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Client's name: _____
   First Name Middle Name Last Name

2. Date of Birth: ___/___/___

3. Date authorization initiated: ___/___/___

4. Authorization initiated by:

   _____
   Name (client, provider, or other)

5. Information to be released:

   ☐ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

   ☐ Other (describe information in detail):

   _____

6. Purpose of Disclosure: The reason I am authorizing release is:

   ☐ My request

   ☐ Other (describe):

   _____

7. Person(s) Authorized to Make the Disclosure:

   _____

8. Person(s) Authorized to Receive the Disclosure:

   _____

9. This Authorization will expire on ___/___/___ or upon the happening of the following event:

   _____

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of the Patient:

_____

Signature of Personal Representative:

_____

Relationship to Patient if Personal Representative:

_____

Date of signature: _____

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date