Insight Child and Family Counseling

Welcome to the office of Jody VanDrimmelen, LCSW. Please complete and sign all attached documents.
Please bring them with you to your first session.

The Initial Session will last 1.5 hrs and ongoing sessions will last 45-50 minutes. I ask that you be on time. I will do my best to do the same. Please understand there are times when I may run behind schedule due to crisis or emergency situations.

Payment will be requested at the time of service in the form of cash or check, or credit card.

On occasion, I may be called away for emergencies that will require me to make schedule changes with short notice. I will make every effort to reschedule you in a timely manner.

I look forward to working with you.

Date: _____

NEW CLIENT INFORMATION

Name: _____Email: _____

Home Phone: _____OK to call and leave a message? ☐ No ☐ Yes

Cell Phone: _____ OK to call and leave a message? ☐ No ☐ Yes

Address _____ City_____ Zip_____

Alternate Number (Description & Number): _____

What is your preferred method of contact?

☐ Cell Phone ☐ Home phone ☐ Alternate Phone ☐ Email

☐ Text (Please provide wireless provider) _____ ☐ Other _____

Date of Birth: _____-_____-_____ Age: _____ Sex: ☐ F ☐ M

Referred by:

_____

Person to contact in case of an emergency: _____

Relationship to you: _____ Contact Phone: _____

FAMILY INFORMATION

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unmarried

If married, length of time in present marriage: _____ If divorced/widowed/separated, length of time: _____

Occupation: _____ Currently employed? ☐ No ☐ Yes

Employed by: _____

Yearly Income of Family: ☐ Less than $10,000 ☐ $10,000-$15,000 ☐ $15,000-$25,000

☐ $25,000-$35,000 ☐ $35,000-$45,000 ☐ $45,000 +

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List the members of your current household in order of their age, beginning with the oldest.

Name	Age	M/F	Current Level of Education

Client was raised by: ☐ Both Biological Parents ☐ Adoptive Parents ☐ Foster Family ☐ Other_____

☐ Mother and Stepfather ☐ Mother only ☐Father and Stepmother ☐ Father only

List the members of the family in which client grew up in order of their ages, beginning with the oldest.

Please include the client.

Name	Age	M/F	Did this person have any Psychological issues/Substance abuse- Describe

MEDICAL HISTORY

Please list any prescription medications you are currently taking (name, dose, frequency) :

_____ _____

_____ _____

Please list any over the counter medications you are currently taking (name, dose, frequency):

_____

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Please list any past or present medical conditions for which you have been treated:

_____

_____

_____

How long since your last complete physical? _____

Average house of sleep per night?_____

Previous Sleep remedies tried_____

MENTAL HEALTH HISTORY

Have you ever received Psychiatric or Psychological treatment of any kind before ☐ No ☐ Yes

If so, please provide information on the level of care: ☐ In-patient ☐ Out-patient ☐ Both

Please indicate the reason for your previous treatment: _____

When and where were you in treatment? _____

How long were you in treatment? _____

Are you currently seeing a Psychiatrist? ☐ No ☐ Yes

If yes, Who _____How Often _____

Have you ever taken medication for psychological reasons? ☐ No ☐ Yes

If yes, name & purpose of the medication:_____

Are you currently taking any psychotropic medication? ☐ No ☐ Yes

If yes, name & purpose of the medications

_____

_____

Other agencies or individuals from whom you have received (or are now receiving) counseling :

Name	***Address***	***Dates***
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had a neurological examination? ☐ No ☐ Yes

If yes, results _____

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HABITS AND SUBSTANCE ABUSE

	Current usage	Most ever used
Coffee/caffeinated drinks (daily quantity)	_____	_____
Cigarettes (packs per day)	_____	_____
Alcohol (please specify type/weekly)	_____	_____
Drugs (please specify type/weekly)	_____	_____

Are you Sexual active? ☐ No ☐ Yes

Do you exercise regularly? ☐ No ☐ Yes If yes, how often and how many minutes?

PRESENTING ISSUES

Describe what issue(s) brings you to this counseling session?_____

_____

_____

_____

_____

_____

When were you first aware that you needed help with this issue(s)?_____

How have you attempted to deal with this issue(s) before now?_____

HOW ARE YOUR ISSUES AFFECTING YOUR LIFE?

	No effect	Little effect	Some effect	Much effect	Significant effect
Marriage/Relationship					
Family					
Job/School Performance					
Friendships					
Financial Situation					
Physical Health					
Sleeping Habits					
Eating habits					
Anxiety Level					
Mood					
Suicidal or Self-Harming Thoughts					
Ability to Concentrate					
Ability to Manager Anger					
Spirituality					

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REACHING YOUR THERAPIST

REGULAR BUSINESS HOURS
Monday through Friday
Between the hours of 8:00 AM and 5:00 PM
Call (682)238-0640

Generally our office staff will be able to take your call during these hours. If we are away from the desk or on another line, you may receive our voice mail. Please feel free to leave a message and we will get back to you as quickly as possible.

AFTER HOURS AND WEEKENDS
Call (682)238-0640

After calling our main number, you will be transferred to our voice mail. Please feel free to leave a message and we will get back to you on the next business day.

*****If it is an emergency please do not leave a message on the voice mail*****

EMERGENCIES:

If you are in an emergency situation and need help immediately, please call one of the following numbers:

- ✓ **EMERGENCY 911**
- ✓ **Suicide Crisis Line (214) 828- 1000**
- ✓ **Harris Methodist - Springwood- Bedford (817)355-7700**
- ✓ **Huguley Behavioral Health- Burleson (817)568-5950**
- ✓ **JPS Psych Services – Ft. Worth (817)927-4151**
- ✓ **Millwood - Arlington (817)261-3121**

If you have any questions, please ask your therapist for clarification of this policy.
Thank you.

_____ _____

Client Signature Date

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PROFESSIONAL DISCLOSURE AND POLICY STATEMENT (PDPS)

THE COUNSELING PROCESS

Counseling, also known as psychotherapy, is a learning process designed to help you better understand yourself and your relationship. While specific goals may vary, generally speaking, counseling is intended to increase the quality of your relationships with yourself and others. This process can also help clarify thoughts and feelings to enable you to make more effective decisions in your life. Additionally, counseling can assist you in accepting your responsibilities and facing personal issues in a direct way. Patience, self-awareness and forgiveness are frequently a part of this process. Most counseling takes time to be effective.

It is not uncommon to have weekly sessions for *six to twenty-four weeks*. Under some circumstances, counseling may last several years. While counseling has been demonstrated to be of benefit for many people in a variety of situations, there is no guarantee of a specific result. As with all types of treatment, there are both benefits and risks. Benefits may include a decrease in depressive symptoms, anxiety, loneliness, or anger. Your relationships and communication skills may improve. Your ability to cope with social, family, and work relationship may also improve, as well as offering you more satisfaction in these relationships. You may also better understand yourself, including a clearer understanding of your motives and values, making it easier for you to make decisions. Your presenting problem may be eliminated, or you may develop skills and see other options for dealing with your presenting problem. You may develop helpful techniques that reduce stress and resolve issues which have troubled you for years.

On the other hand, risks may include the experience of uncomfortable levels of feeling and recalling unpleasant aspects of your personal history. Relationships may change and become more conflictual. Despite all of our best efforts, counseling may simply not work out well for you.

Caveat

Confronting personal secrets in counseling frequently leads to relief and personal growth in relationships. However, confronting individual or family secrets about feelings, money, sex, power, violence, infidelity, and misbehavior can be very unsettling. The counseling process may involve emotional experiences which can be upsetting and even hazardous to personal stability, especially if the problems are partially due to repression of feelings and denial, or other personality defenses. Counseling requires thinking and feeling at deeper levels of personal awareness. For some, the experience of examining themselves and their relationships can be very uncomfortable and disturbing, especially to persons whose lives and relationships are rigidly defined. In addition, while some people experience relief early in the counseling process, they may also experience taking two steps back in order to take one step forward.

Moreover, the results of counseling may affect other individuals who are not attending the session. The counseling of families, couples, children and adolescents, will almost always involve important shifts in the entire family.

Discussing emotional issues can be stressful and upsetting. If this occurs in our session, caution should be taken when leaving your counseling session. Your ability to stay focused on any activity including those that can be hazardous, such as driving a car or operating heavy equipment, may be affected. If you experience such emotional distress, it is important to make arrangements to ensure your safety when leaving your counseling session, such as alternative forms of transportation.

PDPS CONT: THE COUNSELING RELATIONSHIP

Although our sessions will be very intimate, it is important for you to understand that you have a professional, rather than a personal relationship, with your counselor. Please do not invite your counselor to social gatherings or offer gifts. You will be best served by keeping your relationship strictly professional. You will likely have a variety of feelings about your counselor as you work together. This is a very normal part of the counseling process. Your counselor will be giving you support including feedback and confrontation when they think it could be helpful. You may have intense feelings about your counselor doing this, and it will be important for you to discuss those feelings with your counselor. In the event that you become angry with your counselor or dissatisfied with your work together, it will be important for you to talk to your counselor about it. Frequently, discussions about these kinds of feeling can lead to important insights and significant progress.

As a client, you have the right to the following:

1) Ask questions regarding any aspect of your counseling at any time;
2) Ask questions about issues relevant to the counseling you are receiving, such as the counselor's attitudes or values;
3) Be fully informed of the counselor's qualifications to practice, including training and credentials, years of experience, areas of specialization and limitations;
4) Be fully informed of the limits of confidentiality in the counseling setting, including with whom and under what circumstances the counselor may discuss the case;
5) Be fully informed of the extent of written or taped records of your counseling and their accessibility;
6) Be fully informed of your diagnosis;
7) Be fully informed regarding your counselor's estimation of the approximate length of time required to meet your agreed upon goals;
8) Be fully informed regarding the format of counseling;
9) Be fully informed regarding the fees for counseling and methods of payment, including insurance reimbursement;
10) Be fully informed regarding the counselor's policies on issues such as missed appointments and emergency coverage;
11) Specify or negotiate counseling goals and to renegotiate these when necessary;
12) Refuse any particular intervention or counseling strategy;
13) Request that the counselor evaluate the progress of therapy;
14) Refuse to answer any questions;
15) Terminate therapy at any time.

Consumer complaints regarding Jody VanDrimmelen, LCSW may be reported to the following organization:

Texas State Board of Social Workers
Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369

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PDPS CONT: CONFIDENTIALITY

All information between the counselor and the client is held in strict confidence by the counselor with the following exceptions:

1. The client authorizes release of information, by signature on a Release of Information Form.
2. Information that must be provided by insurance companies, and/or EAP entities as required for the payment of claims, certification/authorization or case management or other purposes related to the benefits of client's health plan.
3. The client presents a physical danger to self or others.
4. Child/Elder abuse/neglect is suspected.

Please note that in the latter two cases, we are required by law to inform legal authorities so that protective measures can be taken.

- ❖ I have read and understand the Confidentiality Statement provided to me by my counselor.

BISHOP, SPOUSE, PARENT, FRIEND

- ❖ I give my therapist permission to also notify the following person(s):

Name: _____

Address: _____

Telephone: _____

Relation: _____

Name: _____

Address: _____

Telephone: _____

Relation: _____

I, _____, understand that, if I am in imminent danger of harming myself or others:

- ❖ My therapist *may notify medical or law enforcement personnel* without my permission.
- ❖ I understand that my therapist is *required by law* to report suspected child or elder abuse
- ❖ I understand that the use of third party payment resources often require reporting by my therapist of otherwise confidential information, such as diagnosis of a mental disorder.

Signed by client: **Date:**

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PDPS CONT: CLIENT RESPONSIBILITIES

As a client, you have the responsibilities to the following:

1) Ask for what you want in a direct way and ask questions if you need clarification;
2) Set and keep appointments with us and let us know as soon as possible if you can't keep an appointment to avoid charges;
3) Focus on what you came here to accomplish and work to accomplish your goals;
4) Be honest with me;
5) Provide information regarding previous treatment;
6) Follow through with assignments to which you agree;
7) Keep me informed of your difficulties and progress as we work together;
8) Pay your fees on time and discuss any financial difficulties you may have with me;

Your counselor has a right to terminate treatment if fees are not paid in a timely manner.

Signed by client: **Date:**

CANCELLATION POLICY

_____ (Initial) Due to a recent increase in cancellations without notice, we are regretfully implementing a cancellation fee. Should you cancel or miss your appointment, and do not notify Insight Child and Family Counseling at least twenty-four hours in advance, you will be charged a cancelation fee of $45.

OFFICE POLICIES

APPOINTMENT TIMES: counseling sessions begin by appointment time and are fifty minutes in length. Exceptions may be negotiated if warranted by circumstances.

FEES: The first 1.5 hour session will be billed at the rate of $135 and each additional session will be billed at the rate of $90. We accept cash, checks, credit and debit cards. You are responsible to file claims with your insurance company should you desire.

EMERGENCIES: If in our opinion your situation requires more immediate attention than your counselor is able to provide, emergency help can be provided by calling one of the following:

- ✓ **EMERGENCY 911**
- ✓ **Suicide Crisis Line (214) 828- 1000**
- ✓ **Harris Methodist - Springwood- Bedford (817)355-7700**
- ✓ **Huguley Behavioral Health- Burleson (817)568-5950**
- ✓ **JPS Psych Services – Ft. Worth (817)927-4151**
- ✓ **Millwood - Arlington (817)261-3121**

If the emergency is of life threatening proportions, (1) call your physician or "911", or go to the nearest emergency room or hospital of your choice; then (2) call our office to ensure proper arrangements for follow up care.

On occasion, when your counselor is out of town, if you are in need of assistance, please call your psychiatrist or other therapist if they are available to you. If you do not have a psychiatrist or other therapist, your counselor can provide a therapist's name upon request for you.

If you do not state that you have an emergency, your counselor will return your call at their earliest convenience. Usually within twenty-four hours, or the next business day.

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I acknowledge that I have received, read, and understand the **PROFFESIONAL DISCLOSURE AND POLICIES STATEMENT** and have been completely informed of the facts relating to this document. All questions concerning this document, counseling methods, and options have been answered to my satisfaction. If I have any further questions, I understand that this counselor will either answer them or find answers for me.

As outlined in the **PROFESSIONAL DISCLOSURE AND POLICIES STATEMENT**.

- I understand there are exceptions to my confidentiality rights
- I understand counseling may not, by itself, resolve my problems or concerns. I am aware the practice of counseling is not an exact science and so predictions of the effects are not guaranteed. I acknowledge no guarantees have been made to me regarding the results or procedures provided.
- I realize counseling may involve discussing relationships and/or emotional issues that may at times be distressing. I also realize this process is intended to help me personally and with my relationships.
- I acknowledge counseling may make an impact well beyond myself. The results of my work in counseling may affect other individuals close to me, such as family members, marital partners and/or close friends.
- I understand the counselor may make suggestions and/or referrals to outside sources which are intended to be therapeutic, and that I am not required to pursue those recommendations. However, I also understand that in the event I refuse to fail to follow any recommendations given to me by the counselor that I will be held personally responsible for the result.
- I agree (1) to be contacted by phone and mail using address and phone number I have provided; (2) to pay a cancelation fee of $45 for sessions which I miss with less than a 24 hours notice; and (3) in the event my account is 30 days past due, to pay for all costs incurred in the collection process.

_____ _____

Client Signature Date

_____ _____

Significant Other Signature (if participating in counseling) Date

_____ _____

Counselor Signature Date

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CONSENT FOR TREATMENT

I understand a signed copy of this **CONSENT FOR TREATMENT** will be part of my case record.

I authorize and request Jody VanDrimmelen, LCSW carry out psychological assessments, diagnostic procedures and/or treatments which, now or during the course of my care as a client are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable.

Client Signature _____Date_____

I have read, understand, and agree to abide by each and every provision of the **PROFESSIONAL DISCLOSURE AND POLICIES STATEMENT** and this **CONSENT FOR TREATMENT.** I give my consent to receive counseling under the terms and conditions outlined in these documents.

_____ _____
Client Signature Date

_____ _____
Significant Other Signature (if participating in counseling) Date

_____ _____
Counselor Signature Date

NON-COMPLIANCE AND RE-ASSESSMENT SHEET

I, _____ understand that my status as a client will be reassessed if I have three consecutive appointments which I do not keep and which I have not notified my therapist of the cancellation at least twenty-four hours in advance of that appointment. Such no shows can be grounds for termination of client-therapist relationship on the part of my therapist.

I also understand that it is my responsibility to call, twenty-four hours in advance of the appointment, if I need to cancel it. Should you cancel or miss your appointment, and do not notify us at least twenty-four hours in advance, you will be charged $45.

I, _____ also understand that the client-therapist relationship can be terminated by the therapist if I am non-compliant in keeping my treatment plan goals, if I show major resistance to my treatment, and I am not willing to take my prescribed medications.

_____ _____
Client Signature Date

_____ _____
Significant Other Signature (if participating in counseling) Date

_____ _____
Counselor Signature Date

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d) effective June 2013**Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information.** Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally au disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED

_____

DATE OF BIRTH Month _____Day _____ Year_____

ADDRESS _____

CITY _____**STATE**_____ **ZIP**_____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

REASON FOR DISCLOSURE
(Please check only one option below)

	Treatment/Continuing Medical Care Personal Use
	Billing or Claims
	Insurance
	Legal Purposes
	Disability Determination
	School
	Employment
	Other

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

	All Health Information		Progress Notes ¨
	History/Physical Exam		Discharge Summary ¨
	Lab Results		Physicians Orders
	Diagnostic Test Reports		EKG/Cardiology Reports
	Patient Allergies ¨		Pathology Reports ¨
	Operation Reports		Billing Information
	Consultation Reports		All Mental Health Records
	Radiology Reports		Other

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Genetic Information (including Genetic Test Results)
_____Drug, Alcohol, or Substance Abuse Records
_____HIV/AIDS Test Results/Treatment

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:
Person/Organization Name _____ _____

Address _____

City _____ State _____ Z ip Code _____

Phone (_____)_____Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?
Person/Organization Name _____ _____

Address _____

City _____ State _____ ZIp Code _____

Phone (_____)_____Fax (_____)_____

SIGNATURE X_____**DATE**_____

OR Signature of Individual or Individual's Legally Authorized Representative

Printed Name of Legally Authorized Representative (if applicable):

_____

If representative, specify relationship to the individual: ¨ Parent of minor ¨ Guardian ¨ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE OF MINOR INDIVIDUAL X_____**DATE**_____

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):
Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Important Information About the Authorization to Disclose Protected Health Information

Developed for Texas Health & Safety Code § 181.154(d) effective June 2013

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:
• Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
• Drug, alcohol, or substance abuse records.
• Records or tests relating to HIV/AIDS.
• Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual' s health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive

protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified per son or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and pur poses permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information r elated to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

ight to Receive Copy – The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)).

Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirement s of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**
Covered entities from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law . (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).
The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

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CLIENT CONSENT FORM

I understand that as part of my healthcare, the undersigned therapist originates and maintains health records describing my health history, symptoms, evaluations and test results, diagnosis, treatment, psychotherapy notes, and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The *Notice of Privacy Practices* for Insight Child and Family Counseling
Jody VanDrimmelen, LCSW provides specific information and a thorough description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and I have been given the opportunity to review the notice prior to signing this consent. Before implementation of any revised *Notice of Privacy Practices*, the revised *Notice* will be mailed to me at the address I designate below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare operations and that I am not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Kline Counseling has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure
of my personal health information.

_____

Therapist response: Agree to restriction/Do not agree to restriction

I request the following restrictions on the use and/or disclosure
of my personal health information.

_____

Therapist response: Agree to restriction/Do not agree to restriction

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have received the Insight Child and Family *Notice of Privacy Practices.*

_____ _____

Signature of Client or Legal Representative/Date Signature of Client or Legal Representative/Date

I request that changes to the *Notice of Privacy Practices* be sent to me at this address:

_____

Witnessed Date:

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