New Beginnings Counseling

Carolyn Williams, M.A., L.P.C.

Date _____

Client Information

Name Last First	**Date of Birth** / /	**Sex** M/F	**Marital Status** ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed
If child, parent's or guardian's name			
Address City State Zip Code			
Home Phone ( )	**Business Phone** ( )	**Cell Phone** ( )	
Employer or School	**Address** City State Zip Code		
In Case of Emergency, contact Name	**Home Phone / Cell Phone** ( )	**Business Phone** ( )	
Preferred Contact Number	**Is It Ok To Leave A Message?** ☐ Yes ☐ No	**Is Texting Ok?** ☐ Yes ☐ No	**Referred By**

Family Information/History

Family Members Living at Home

Name	Age	Relationship

Please comment on any member of your immediate or extended family who suffers/suffered from a mental health problem, substance abuse, eating disorder, or has been physically/sexually abused and treatment they received.

Personal Information

Previous counseling or treatment received for mental health, family or social problems?

- ◯ No
- ◯ Yes

With whom? Dates

Name of your Primary Care Physician

Mailing Address City State Zip Code Phone ( )

List Medications Currently Taking and Reason for Medication

Name	Dosage/Times per Day	Reason for Medication

Do you currently experience any of the following

- ☐ Anxiety/Tension
- ☐ Sleep Problems
- ☐ Allergies
- ☐ Stress Problems
- ☐ Nausea
- ☐ Agitation
- ☐ Frequent Headaches
- ☐ Overactivity
- ☐ Depression
- ☐ Suicidal Thoughts
- ☐ Guilt
- ☐ Fatigue
- ☐ Short Attention Span
- ☐ Change in Appetite
- ☐ Heart Palpitations
- ☐ Dizziness
- ☐ Anger Problems
- ☐ Excessive Worry
- ☐ Work Related Problems
- ☐ Marital Problems
- ☐ Alcohol/Drug Problems
- ☐ Panic Attacks
- ☐ Financial Problems
- ☐ Eating Problems
- ☐ Phobias
- ☐ Sexual Problems
- ☐ Body Image Concerns
- ☐ Lack of Ambition/Goals
- ☐ Feelings of Inferiority
- ☐ Stomach Problems
- ☐ Shortness of Breath without Exertion

List any major illness and/or current physical health problems not listed above or recent life changes.

What is your main concern/reason for seeking help?

What are your strengths?

What are your weaknesses?

Spiritual / religious preference? **If church attendance, what church do you attend?**

Is there anything that has not been covered elsewhere that you want your therapist to know about you? If so, please write it in the space below.

New Beginnings Counseling
Carolyn Williams, M.A., L.P.C.

Office and Financial Policy

Please read and indicate that you understand and agree to the following office and financial statement by signing. Feel free to ask any questions you may have regarding this policy.

Fee

The usual and customary fee for Individual, Marital and Family Therapy is $130.00 for a 50 minute session. This fee may be periodically adjusted with advance notice. Phone calls in excess of 5 minutes will be billed at the normal fee in 15 minute increments. The fee to prepare documents for Disability Insurance claims will be charged at the standard rate of service. Please be advised that Carolyn Williams is not on any insurance panels so is unable to receive any form of insurance payment.

Responsible Party

The client is responsible for all charges. The parent(s) or guardian(s) are responsible for charges of dependent children and adolescents. New Beginnings Counseling is an out-of-network provider. If you choose to file a claim with your insurance company, a receipt documenting necessary information will be provided. Please be advised that for reimbursement from most insurance companies, the counselor must assign a mental health diagnosis.

Payment

Payment is due at the beginning of session. Cash, checks, Health Savings Account, Visa, Master Card, and American Express are accepted. Please make checks payable to **Carolyn Williams**. There is a **$25.00** charge on all returned checks, even if payment is made after a second deposit.

Emergency Situations

If a crisis occurs, call **911** or **have someone take you to your nearest hospital emergency room or other emergency facility**, so you can get the help and support you need.

Cancellation Policy

There is a **24-hour cancellation** policy. All scheduled appointments not kept or broken within 24 hours of your reserved time will be charged at the normal fee.

Legal Fees

The therapist will only participate in litigation or a custody dispute if subpoenaed. In the case of a subpoena, it is fully understood that I may bill the client at a rate of **$200.00** per hour for all services including, but not limited to: attorney consultation, document review, court testimony, wait time in court, report writing, case correspondence, travel time, and all other services related to the client's case. For court appearances or any other legal meeting, a minimum charge of eight **(8)** hours per day will be assessed. Each cancellation or rescheduling of any court hearing or meeting that occurs with less than **24 hours** notice will be charged a **$200.00** cancellation fee. The therapist asks that clients request a court appearance, other legal meeting, or disclosure of psychotherapy records, only in **extreme** cases.

Confidentiality Policy

Client records and information obtained in the course of treatment will remain confidential excluding exceptions and limitations based upon state law and ethical guidelines and rules governing counselors.

General Exceptions: Disclosure of confidential information is permitted under the following circumstances:

1. If I determine the client poses a danger to self or others, I have a duty to warn and protect the endangered person by notifying medical or law enforcement personnel.
2. To clerical assistants involved in management of treatment.
3. When client requests release of information to self or third parties.
4. To those involved in paying or collecting fees for psychological services rendered.
5. When counselor consults with other professionals.
6. To government agencies if disclosure is required or authorized by law.
7. In civil or criminal actions if records are subpoenaed.
8. If physical, sexual, or mental abuse of a child, adolescent, or senior citizen is suspected.
9. To the parents or guardians of a minor child.
10. When a minor child is seeking treatment without the consent of the parents or guardians for sexual abuse, physical abuse, suicide prevention, chemical addiction or dependency.

Incapacity or Death: I understand that in the event of the termination of this therapist's counseling practice, incapacitation, or death, it will be necessary to assign my case and treatment records to another therapist. By my signature on this form, I hereby consent to said licensed mental health professional selected by this therapist, to take possession of my records.

Marital or Family Therapy: Limitations of confidentiality are also applicable to the clients involved in marital or family therapy since it typically involves meeting with all parties on some occasions and individuals on other occasions. My policy is not to attempt to maintain confidentiality between those participating in marital or family therapy (except where specifically requested by clients) since open communication between marital and family therapy participants is encouraged as a means of resolving problems more effectively.

I have read, understand and agree to this office and financial policy.

Signature_____ Date_____

Client or person financially responsible for the bill

Informed Consent

As your counselor I have an ethical obligation to provide information that will help you make an informed choice regarding your participation in therapy.

My method of treatment is based on each client's needs. Techniques may include re-framing, disputing irrational beliefs, changing one's language, confrontation, cognitive restructuring, and homework assignments. At any time you may ask me to explain my approach or ask for clarification. Treatment may include individual, marital, or family psychotherapy. Some risks associated with counseling are that counseling by itself may not resolve your problem or concern, progress may seem slow, therapy requires your desire to progress, and because of increased awareness, counseling may cause you emotional pain and anxiety. As clients become more self-aware and self-accepting, I believe they are more capable of facing life's challenges, behaving more responsibly, and finding contentment in their lives. Some clients need only a few counseling sessions to achieve this outcome, whereas others require extended counseling. While it is impossible to guarantee any specific results regarding your counseling goals, together we will work to achieve the best possible results for you. As a client you have the right to terminate our counseling relationship at any point, although this is best accomplished in consultation with your therapist. Also, there are many alternatives to traditional therapy including self-help programs, bibliotherapy, twelve-step programs, support groups, and crisis-intervention centers. I often request that clients participate in one or more of these programs as an adjunct to counseling.

As the client I understand that receiving counseling may involve discussing emotional, psychological, spiritual, and/or relational issues that may at times be disturbing. I understand that counseling by itself may not resolve my problem or concern, progress may seem slow, therapy requires my active participation to progress, and because of increased awareness I may experience emotional pain and anxiety. I am also aware that there are alternative treatment facilities available to me. I am aware that my treatment may include individual, marital, or family psychotherapy. I understand that if I have further questions related to the therapeutic process, my therapist will either answer them or find answers for me. I understand that I may discontinue therapy at anytime, although I am aware that this is best accomplished in consultation with my therapist.

I have read and understand the previous statements. My signature below indicates that I give my full and informed consent to receive therapeutic services from Carolyn Williams.

Client Signature_____ Date_____

New Beginnings Counseling
Carolyn Williams, M.A., LPC

HIPAA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.
I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:
1. For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.
2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**

4. **If disclosure is compelled by the patient or the patient's representative pursuant to Texas Health and Safety Codes or to corresponding federal statutes of regulations**, such as the Privacy Rule that requires this Notice.
5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by the Texas Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.
8. **If disclosure is mandated by the Texas Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
14. **For Workers' Compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.
15. **Appointment reminders and health related benefits or services.** Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer**.**
16. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. **I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other heath-related benefits and services that may be of interest to you.**
18. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
19. **If disclosure is otherwise specifically required by law.**

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate

method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI. I will provide a copy of the amended notice to you upon request.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me in writing at New Beginnings Counseling, J. Carolyn Williams, 200 Rufe Snow Drive North, Suite 207, Keller, TX 76248, or call me at 817.337.5292.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

My signature below indicates that I have read and understand the Notice of Privacy Practices. I understand that I am entitled to receive a copy of this document.

Client Name: _____Date: _____

Signature: _____

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Client Name _____

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as Ahealth care operations.@). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review The Notice of Privacy Practices before signing this consent. I reserve the right to revise our Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

Signature of Client: _____ Date: _____

New Beginnings Counseling
Carolyn Williams, M.A., LPC

Permission for Telehealth Visits

What is telehealth?

Telehealth is a way to visit with your Counselor. You can talk to your Counselor from any place, including your home.

How do I use telehealth?

- You talk to your Counselor by phone.
- Sometimes, you use video so you and your Counselor can see each other.

How does telehealth help me?

- You don't have to go to an office to see your Counselor.

Can telehealth be bad for me?

- Your Counselor may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?

- There is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I try telehealth and don't like it?

- You can choose in-office visits instead of telehealth at any time.

How much does a telehealth visit cost?

- A telehealth visit is billed at the same rate as an in-office appointment.

What does it mean if I sign this document?

If you sign this document, you agree that:

- All your questions were answered.
- You want a telehealth visit.

Client name (please print)	Date
Client signature	Date