Julie Casten, MA, LPC
JC Counseling, PLLC
16712 Huffmeister Rd, Bldg 400B
Cypress, TX 77429

PERSONAL INFORMATION FORM – CHILDREN AND YOUTH

NAME _____

ADDRESS _____

PHONE (cell Y/N) _____ EMAIL _____

MAILING ADDRESS (if different from above) :_____

EDUCATION:

Grade _____School_____Any Grade Level Retention? Y/N

PERSON RESPONSIBLE FOR PAYMENT:_____Child DOB:_____

PERSON WHO REFERRED YOU TO ME:_____

May I send a note of thanks for the referral? ( ) Yes ( ) No

FAMILY OF ORIGIN ATMOSPHERE:

Father's Name_____ Age____	Mother's Name_____ Age____
Father's Phone _____	Mother's Phone _____
Father's Email _____	Mother's Email _____
Living ( ) Deceased ( ) Date_____	Living ( ) Deceased ( ) Date_____
Address_____	Address_____
_____	_____
Phone (H)_____ (W)_____	Phone (H)_____ (W)_____
(C)_____	(C)_____
Occupation_____	Occupation_____
Employer_____	Employer_____
Address_____	Address_____
_____	_____
Birthdate_____	Birthdate_____

Parents separated or divorced? No ( ) Yes ( ) Child's age at time of separation/divorce_____

Did you have step-parents? No ( ) Yes ( ) Your age at time of parent remarriage_____

List brothers and sisters from oldest to youngest (include child coming for therapy)(Circle step-siblings)_____

_____

All living? Yes ( ) No ( ) If no, name(s) of deceased and date_____

Which of the siblings is the child most like?_____ How?_____

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Which of the siblings is the child least like?_____ How?_____

Which of the siblings is the child in most conflict with?_____ Why?_____

Which sibling is more like Mom?_____How?_____

Which sibling is more like Dad?_____How?_____

Describe the relationship between you and your spouse._____

_____

_____

Who makes the decisions?_____ Do you agree on child rearing methods?_____

Do you disagree openly?_____About what?_____

Describe other environmental influences on the child._____

Who has been important to the child (Grandparents, other relatives, friends or neighbors)?_____

In what way?_____

Do any of the family members use alcohol or other drugs? Yes ( ) No ( ) If so, to what extent?_____

Is this a family problem? Yes ( ) No ( ) If so, how do you cope?_____

Any other pertinent family history/information:_____

_____

_____

PERCEPTION OF THE CHILD:

How does the child stand out in the family?_____

What has he/she been successful at?_____

What does he/she get into trouble for?_____

What does the child want to be when he/she grows up?_____

What are the child's responsibilities (getting self up in the morning, to sleep at night, household chores, pets, etc)?_____

_____

_____

Does the child have nightmares or dreams? Yes ( ) No ( ) How often?_____

What are the dreams about?_____

Does your child:

Get feelings hurt easily? Yes ( ) No ( )	Have any friends? Yes ( ) No ( )	Athletic? Yes ( ) No ( )
Have a bad temper? Yes ( ) No ( )	Have high standards? Yes ( ) No ( )	Follow rules? Yes ( ) No ( )
Complain/find fault? Yes ( ) No ( )	Try to please others? Yes ( ) No ( )	Acts selfishly? Yes ( ) No ( )

Do nice things for others? Yes ( ) No ( ) Help around the house? Yes ( ) No ( ) Like to be alone ( ) or with others ( )

FUNCTIONING AT LIFE TASKS:

How does child get along with adults?_____

Favorite adult to be with?_____Least favorite?_____

How does child get along with children in the neighborhood?_____

Does child prefer to play with other children of the same age, younger, or older?_____

How does child get along with peers at school?_____

Does child have a best friend?_____ Describe him/her: _____

Does the friend come over very often?_____

How do things go for him/her at school?_____

_____

What does he/she get into trouble about at school?_____

What do you do about it?_____

Does child make good grades? Yes ( ) No ( )

TRAUMA IN THE FAMILY:

What traumatic events have occurred during the child's life (divorce, death, abuse observed, etc.)?_____

_____

_____

BEHAVIORS:

If any, what are some of the behaviors that the child engages in that are annoying to you or to other family members?_____

_____

What do you do in response to these annoying behaviors? _____

_____

How do you feel if these annoying behaviors persist?_____

What does the child do in response to discipline? _____

RELIGION: _____

Religion is: Satisfying ( ) Challenging ( ) Dull ( ) Meaningless ( ) Irrelevant ( )

HEALTH:

General Condition: Excellent ( ) Good ( ) Fair ( ) Poor ( ) Date of last physical _____

Physical Disabilities or Limitations: _____

_____

Current Medications and Dosage:_____

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Injury/Illness/Allergies:_____

Has child ever contemplated or attempted suicide? Yes ( ) No ( ) If yes, when? _____

Has child ever contemplated or intentionally harmed another person? Yes ( ) No ( ) If yes, when? _____

Sleep Pattern: Normal ( ) Restless/Broken ( ) Insomnia ( ) Oversleep/Hard to Wake ( ) Nightmares ( )

Substance Use? (Alcohol, Tobacco, Illicit Drugs) Yes ( ) No ( ) If yes, what, when, and/or how often? _____

_____

PREVIOUS COUNSELING OR PSYCHOTHERAPY? Yes ( ) No ( ) If yes, when? _____

Received from: _____ Phone: _____

PLEASE RATE CHILD'S OVERALL HAPPINESS 1-5 (1=AWFUL; 5=GREAT):_____

DREAMS FOR THE CHILD:

What are your hopes for the child?_____

_____

_____

_____

Is there anything else that I should know about him/her? _____

_____

_____

PLEASE HAVE CHILD COMPLETE THE FOLLOWING SENTENCES:

Some of my strength are...

Fun for me is...

I came here today...

Six months from now...

I testify to the best of my knowledge, the information provided above is accurate and complete. I further grant permission for Julie Casten, MA, LPC to consult and share, should she deem it necessary, pertinent information concerning me (my child) with other professionals in order to aid my counseling/growth process.

_____ _____

Client/Guardian Signature Date

Julie Casten, MA, LPC
JC Counseling, PLLC
16712 Huffmeister Rd, Bldg 400B
Cypress, TX 77429

INFORMED CONSENT – PRIVACY POLICY – THERAPY AGREEMENT

Welcome! This document answers many questions clients often ask about therapy and explains procedures, expectations, and privacy policy. A separate document will go further into our privacy practices and explain the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future. After reading and fully understanding its contents, you will be asked to initial each page and sign the agreement. Please retain a copy for your records/ reference.

SESSION FEES:

Intake (60 minutes) **$175** Couple/Family (60 minutes): **$190** Individual/Child (60 minutes): **$150**

All professional time will be billed for at a rate of $4 per minute. This includes writing or reading reports or letters on your behalf, scoring of rating scales/evaluations, consultation/phone calls, email communication, extended sessions, copying/mailing of records, off-site observations (including travel time), etc. While there is no charge for calls to schedule/change appointments, inquire about services, etc., after hours consultation calls are charged 150% of the usual rate.

Your session time is for you and is taken seriously. *You are contracting for the time you have scheduled.* Please make every attempt to attend your scheduled sessions and arrive on time. **Twenty-four (24) hours notice is required in order to cancel an appointment.** To maintain consistency from one client to another and to maintain flexibility to be able to meet with clients in a timely manner, *exceptions (excluding unavoidable emergencies) will not be made.* **If an appointment is not canceled 24 hours in advance, you will be charged $100 for the missed session.** This helps to eliminate "No Shows" and ensures maximum appointment availability for you.

PAYMENT:

Payment in full for all professional services is due at the time of the service. You (or parent/guardian) are directly responsible for payment. Fees may be adjusted individually, based on the needs of the client when agreed upon by the provider. **Acceptable forms of payment are cash, check (payable to Julie Casten), venmo and zelle. Credit cards are accepted with additional $5 fee. Returned checks are subject to a $45 service fee which must be paid prior to the next appointment, and future payments will be required to be made with cash or money order.** Because payment is due when services are rendered, we usually do not send bills. If, however, a situation necessitates that you be billed, please remit payment within five days of receiving the invoice. Should payment problems arise, they must be worked out openly and quickly. Such problems can greatly interfere with counseling/therapy progress and our working relationship.

Insurance: Your health insurance policy is a contract between you and your insurance company. **You are responsible for knowing your insurance benefits/limitations such as the number of sessions allowed per calendar year, authorized time periods, and so on. It is also your responsibility to let me know if/when your coverage changes.** For the insurance plans I am a network provider, I will file the claim for service, otherwise you are responsible for completing and filing all paperwork for any possible insurance reimbursement. I will provide you with a receipt for services rendered. Should you choose not to use your insurance or you have coverage from a plan I am out of network, you may be eligible for 'out of network' benefits, you will need to research the extent of your coverage to make this determination. I may be required to provide the company with your personal health information, which includes history as well as current status, for you to be reimbursed. Please be aware we have no control or responsibility for confidentiality procedures employed by your insurance company. **By signing this agreement, you agree that we can provide requested information to your carrier if you plan to pay with insurance.**

CONFIDENTIALITY:

All information shared in session is held in strictest confidence according to federal regulations. The following are exceptions: 1) Legal obligation such as child or elder abuse, court subpoena, cooperating with law enforcement officers, etc., 2) Suspected personal danger to yourself or an identifiable victim, 3) Information required by insurance companies for payment (for which you consented), 4) Information provided to parents if the client is a minor, 5) Valid collection of a debt, and/or 6) Consultation with other professionals in order to aid in the counseling/therapy process (identifying information will be withheld unless written permission is given). Release of information to other individuals, agencies, or professionals may only be done with your written consent.

OFFICE HOURS/APPOINTMENTS:
Contact your individual therapist for office days and times. You may ask to have the same time each week for your appointment. We will do our best to accommodate your request, as certain time slots are in demand and fill quickly.

When in session with a client, we will not be able to take phone calls. Please leave a message on our individual voicemail. A session is typically 45-50 minutes with the remaining 10 minutes of the hour to complete paperwork. We make every attempt to return calls daily. Emergency calls may be taken after hours and charged the 'after hours' rate. As we honor and value our personal self-care time and time with family, we ask that you limit after hour calls to emergencies only.

EMERGENCIES:
As a rule, our practice is not crisis oriented in nature. If you feel you will need more intensive after hours support on a regular basis, please inform us during our first session. We will be happy to help you locate a provider whose practice is more suited to on-going crisis intervention.

For an emergency, please attempt to contact your individual therapist. If we cannot be reached immediately by phone, you, your family member, or friend should call the **HOUSTON CRISIS HOTLINE at 713-468-5463, DIAL 911, or GO/BE TAKEN TO THE NEAREST HOSPITAL EMERGENCY ROOM.**

LEGAL MATTERS:
Should you ever become involved in a divorce or custody dispute, **we will not provide evaluation (written or otherwise) or expert testimony in court.** You should hire a different/neutral mental health professional for any evaluation or testimony you require. This position is based on two main reasons: 1) Our statements will be seen as biased in your favor because we have a counseling/therapy relationship, and 2) the testimony may affect the counseling/therapy relationship, and we must put this relationship first. This applies to all clients regardless of age.

If, as part of your session work, you create/provide to us records, notes, artworks, or any other documents or materials, we will return the originals to you at your written request but will retain copies. You have the right to review or get copies of your personal health information with limited exceptions. You must submit a written request and allow a reasonable time period (maximum of 30 days) for compliance. If you are concerned that we have violated your privacy rights, or disagree with a decision we have made in regards to access to your personal health information, please inform us immediately. You also may submit a written complaint to the U.S. Department of Health and Human Services.

Violations: In our practice we follow the professional code of ethics of the American Counseling Association. Any violations of the Licensed Professional Counselor Act should be reported to: Texas State Board of Examiners of Professional Counselors, 1100 West 49th Street, Austin, TX 78756-3183, 512-834-6658.

ABOUT THERAPY:
Seeking help through counseling/therapy is a wonderful way to gain new clarity as well as obtain practical tools to support you in your daily living and in navigating life transitions. Because you will be investing time, energy, and money, it is important to choose a therapist with whom you are comfortable.

Our work together will focus on wellness and increasing overall life satisfaction. Utilizing a problem-solving/skill-building approach, we will work together to identify developmental and/or life issues and concerns with which you may be dealing *and* useful skills to help you address your problems. We will devise a plan to help you incorporate your new skills into your daily living. Homework may be assigned which you will be asked to complete as a means of moving toward the achievement of your goals.

Although no counselor/therapist can ethically guarantee achievement of goals, it has been our experience that the more you put into the process, the better the chance for positive, lasting results. Because the work that we do *is* a process and often has a cumulative effect, *it can be helpful to commit to a minimum number of at least six sessions.*

While you most likely will experience gains in as little as one session, it generally takes longer for deeper work. You or your therapist have the right to terminate this agreement at any time. At least one session's notice is helpful for all involved, should the decision to terminate, by you or by the therapist, occur. This allows for closure. If needed, you will be provided the names and phone numbers of other qualified counselors/therapists.

_____
Initials

The Benefits and Risks of Counseling/Therapy: There may be some risks as well as many benefits with counseling/therapy. You should think about both the benefits and risks when making any treatment decisions. For example, there is a risk that you will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other such feelings. You may recall unpleasant memories which may bother you in settings outside of our sessions. You may receive feedback from some people who mistakenly suggest participating in this process is a sign of weakness. (By the way, we believe investing in your personal growth is a sign of courage and strength!)

Also, this process has the potential to impact your relationships with people who are important to you such as members of your family. You may experience a temporary worsening of problems after beginning, although this usually passes as you learn new skills and increase your self-confidence in applying them. Most of these risks are to be expected when making important changes in your life. Finally, even with our best efforts, there is a risk that counseling/therapy may not work out well for you.

While you consider these risks, you should also know the benefits of counseling/therapy have been scientifically researched and validated. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. Through this work, you will have a chance to talk things out fully until your feelings are relieved or your problems are solved. Your relationships and coping skills may improve greatly, increasing your overall satisfaction. Your personal goals and values may become clearer. You may find yourself growing in many directions and experience an increased ability to live authentically and fully enjoy your life.

What to Expect from Our Relationship: Services are best provided in an atmosphere of trust. You expect us to be honest with you about your problems and progress, and we expect you to be honest with us about your expectations for services, your compliance with medical advice from your doctor, and any other treatment issues. As a Licensed Professional Counselor (LPC), we will use our best knowledge and skills to help you achieve your goals. Our duty is to care for you and my other clients, but *only* in the professional roles of counselor/therapist. Ethically, we are bound to avoid "dual relationships." We are not able to advise you from other professional viewpoints such as law, medicine, finance, etc. We must honor confidentiality (excluding the areas mentioned below as confidentiality exceptions). To maintain privacy, we do not reveal the identities of our clients without their consent. Therefore, if we meet on the street, we may not say hello or talk to you very much. *This would not be a personal reaction to you, but rather an effort to maintain the confidentiality of our relationship.* Lastly, we cannot socialize or have a romantic relationship with any of our clients, and cannot provide counseling/therapy to any family members or friends.

AGREEMENT:

I, _____, confirm that I have read, or have had read to me, in its entirety, this document. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the policies and procedures listed in this document. I understand that no specific promises have been made to me by the therapists at Tranquil Hearts Counseling Center, about the results of treatment, the effectiveness of the procedures used by them, or the number of sessions necessary for therapy to be effective. I understand that after therapy begins, I have the right to withdraw my consent at any time, for any reason. I will make every effort to discuss my concerns about my progress with my therapist before making the decision to end therapy.

I hereby agree to enter into a professional working relationship, as detailed above, with a Tranquil Hearts Counseling Center therapist, (or to have my minor child enter), and to cooperate fully and to the best of my ability, as shown by my signature here.

_____ _____

Signature of Client (Parent/Guardian) Date

Having met and discussed with this client (and/or client's parent/guardian) the policies and procedures outlined in this document and having responded to all questions posed, we believe this person fully understands the information presented. We find no reason to believe this person is not fully competent and capable, legally or otherwise, to give informed consent. Therefore, we, Tranquil Hearts Counseling Center therapists, agree to enter into a professional working relationship, as detailed above, with this client as shown by our signature here.

_____ _____

Signature of Therapist Date

_____

Initials

Julia Casten, MA, LPC
JC Counseling, PLLC
16712 Huffmeister Road, Bldg 400B
Cypress, Texas 77429
(773) 840-0916

Telehealth Informed Consent Form

Telehealth involves the use of electronic information and telecommunication technologies to enable Treatment Providers (healthcare professionals) at different locations to share client clinical information for the purpose of providing healthcare, diagnosis, treatment, transfer of clinical data, therapy, consultation, follow-up and/or education and may include client clinical records and live two-way audio and video. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and information.

I, hereby consent to engage in telehealth with Julia Casten, MA, LPC. I understand that "telehealth" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to telehealth:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the Informed Consent Agreement I received with this consent form.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of Julia Casten, MA, LPC, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
4. In addition, I understand that telehealth based services and care may not be as complete as face-to-face services. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve and in some cases may get worse.
5. I understand that I may benefit from telehealth, but results cannot be guaranteed or assured.
6. I accept that telehealth does not provide emergency services. If I am experiencing an emergency, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.
7. I understand that I am responsible for (1) providing the necessary phone or computer, possibly including internet access or the use of cellular data, (2) the information security on my computer, if applicable, (3) arranging a location with sufficient privacy that is free from distractions or intrusions for my telehealth session.

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8. I understand that while email may be used to communicate with Julia Casten, MA, LPC, confidentiality of emails cannot be guaranteed.
9. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

Client Consent to the use of Telehealth

I have read and understand the information provided above regarding telehealth and understand I have the opportunity to discuss it with my treatment provider. I hereby give my informed consent for the use of telehealth in my clinical care.

I hereby authorize Julia Casten, MA, LPC to use telehealth in the course of my diagnosis and treatment.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Date

Having met and discussed with this client (and/or client's parent/guardian) the policies and procedures outlined in this document and having responded to all questions posed, I believe this person fully understands the information presented. I find no reason to believe this person is not fully competent and capable, legally or otherwise, to give informed consent. Therefore, I agree to enter into a professional working relationship, as detailed above, with this client as shown by my signature here.

_____ _____

Signature of Therapist Date

Julia Casten, MA, LPC
JC Counseling, PLLC
16712 Huffmeister Rd., Bldg 400B
Cypress, TX 77429 p. 773-840-0916

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly with appropriate authorization to share information.
- Obtain payment from third-party payers, if applicable.
- Conduct normal healthcare operations such as quality assessments and record keeping.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

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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 it carefully. Keep this information for your records.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

• Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

• Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

• The right to inspect and copy your protected health information.

• The right to amend your protected health information.

• The right to receive an accounting of disclosures of protected health information.

• The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 1, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights
http://www.hhs.gov/ocr/civilrights/complaints/ind ex.html

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Pre-Authorization Charge Form

I authorize Julia Casten, MA, LPC to keep my signature on file and to charge my Credit Card listed below in the amount of $100.00 for missed appointments and late cancellations.

Please be advised 3rd party payers (i.e., insurance companies) will not reimburse for a missed appointment. You will be responsible for the above agreed amount when appointments are missed or not canceled within 24 hours.

I understand this form is valid for one year unless I cancel the authorization through written notice to the service provider.

Customer's Name: _____

Cardholder's Name: _____

Card Type: (Circle One)

VISA MASTERCARD AMERICAN EXPRESS

Account Number: _____ Billing Zip Code: _____

Expiration Date: _____ Card Verification Code: _____

Cardholder's Signature: _____ Date: _____

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Email and Texting Consent

HIPAA regulations and my professional Code of Ethics both require that I keep your Protected Health Information (PHI) private and secure. Emails and texts are very convenient ways to handle administrative issues like scheduling or receipt requests, but email and texts are not 100% secure. Some of the potential risks you may encounter if we email or text include:

- Misdelivery of email/text to an incorrectly typed address.
- Email/text accounts can be "hacked", giving third party access to email/text content and addresses.
- Email/text providers (i.e., Gmail, Yahoo, etc.) keep a copy of each email/text on their servers, where it may be accessible to employees, etc.

For these reasons, I will not use email/text to discuss clinical issues (i.e., important things we talk about in session). If you are comfortable doing so, I am happy to use email/text (text for appointment reminders only) to handle small administrative matters like scheduling and billing. If you are not comfortable with these risks, we may handle administrative issues via phone calls.

Please indicate **ONE** option for your preference about email/text below and sign.

_____ I do consent to use of email and/or text for administrative matters.
(initials)

_____ I do not consent to use of email and/or text for administrative matters.
(initials)

If given, consent will expire 2 years after our last appointment. Please remember reminders will be sent only via emails or texts. I will respond to you briefly via email but never text.

_____ _____
(Patient's Printed Name) (Patient/Legal Guardian Signature/Date)