Therapy Services Texas, LLC

3509 Hulen Street, Suite 100
Fort Worth, TX 76107
(817) 690-5196
Email: tiffanyderrick@therapyservicestexas.com
Website: https://www.therapyservicestexas.com

Adult

IMPORTANT INFORMATION

Please read and sign that you have read and understand the following.

By making your first appointment you have already made progress. Deciding to participate in therapy shows your courage and willingness to take the steps necessary to improve your life. Therapy can be rewarding, and those who are willing to work and take the necessary risks can experience a life changing process. We look forward to working with you and hope that we can assist you in reaching whatever goals you set.

Effective Therapy is built from good working relationships and requires mutual understanding. It is in the mutual interest of both client and therapist to convey to you the policies and procedures we use in our practice; we are willing to discuss any questions or problems you may have.

Our Fee Schedule:

Individual Counseling

Initial Intake and Assessment		$150.00
Regular Office Visits & Telehealth Sessions	(45 minutes)	$135.00
	(1 hour, 15 minutes)	$165.00
	(1 hour, 30 minutes)	$200.00

Couples Counseling

Initial Intake and Assessment		$175.00
Regular Office Visits & Telehealth Sessions	(60 minutes)	$150.00
	(1 hour, 15 minutes)	$190.00
	(1 hour, 30 minutes)	$225.00

Other Fees

Outside Office Work (Inpatient visits, court testimony, etc.)	$175.00/hour Required
Written Reports (work, supervisors, etc.)	$ 75.00
Text Messaging (exceeding 3)	$ 5.00/text

Fees are based on time.
We do not discriminate on any basis. If we are unable to help with your case, or continued service is no longer in the client's best interest, the therapist will terminate and provide three referrals to other sources.

Payment of Fees:

Fees for face-to-face office visits are payable at each session. Payment is your responsibility. **In order to take full advantage of your session time, it is requested that your check be prepared prior to beginning the session. This will expedite the rescheduling of future appointments.**

Fees and consent forms for telehealth sessions should be mailed to the address below so that they arrive **prior to your scheduled session**. Checks are payable to Tiffany Derrick.

Therapy Services Texas, LLC
P.O. Box 2901
Burleson, Texas 76097-2901

Account Balances:

1. Cancellation fee if an appointment is not cancelled within 24-hours to be charged the following business day.
2. To help control costs we ask our patients to pay their office visits at the time service is rendered.
3. We issue credits in the form of a check to clients a month after the client has completed counseling. Credits include overpayments on a client's account, as well as cash that was placed on file for no-show appointments.

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Appointments and Scheduling:

Appointments are usually scheduled once or twice a week and last approximately 45 minutes. More frequent or intensive outpatient schedules are possible depending upon the circumstances. If you need to reschedule or cancel an appointment, please call (817) 690-5196 and leave a message that you need to reschedule your appointment. You may also email at tiffanyderrick@therapyservicestexas.com if you need to reschedule your appointment. Broken appointments create a loss to everyone. **It is important that communication of changes be made well in advance of your scheduled appointment time whenever possible; a first time missed appointment, or an appointment canceled without 24-hour notice will result in a $75.00 charge. A second time missed appointment, or an appointment cancelled without 24-hour notice will result in a $150.00 charge.** Patients arriving 15 minutes or more, late to the appointment will be considered a no-show and must be rescheduled unless other arrangements are made with the therapist. To help control costs, we ask our patients to pay for their office visit at the time the service is rendered.

No-Shows:

As stated in our paperwork, it is our policy to charge a $75.00 fee for first time no show/late cancel and $150.00 fee for second time and thereafter appointments that are not cancelled at least 24-hours in advance. You may leave notice of cancellation on our voicemail at any time, which will note the day and time you called.

No-Show Policy:

After a no-show appointment, a client is called to inform them of the missed appointment. At that time, client will need to pay the no-show fee of $75.00 through Square to bring account current.

Technical Difficulties for Telehealth "Distance Counseling" Sessions

In case of technical failures, the following procedures will be followed:

(1) My therapist will attempt to reconnect the session 3 times
(2) My therapist will use the back-up telephone number I have provided to contact me to continue or reschedule the session
(3) I will attempt to reach my therapist by telephone
(4) If connection cannot be resumed within 10 minutes, then we will reschedule the remainder of the session at no additional cost

Relationship:

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you. Gifts, bartering and trading services are not appropriate and should not be shared between you and the therapist.

Release of Information:

We require releases to be signed before any information regarding a client is released whether verbally or written from our office to any physician, school personnel, etc.

Wait List Procedures:

New and current clients can ask to be put on the wait list for their counselor. When a cancellation occurs, clients are called and the first client to accept the appointment is the one to receive the appointment. An offer of an appointment through a phone message does not guarantee that the opening will still be available when the call is returned to our office. A client's name is not written in the book for a session until the session has been confirmed by the client.

Emergencies:

For after hours' emergencies, call 911 or Contact Hotline at (817) 335-3022 (Tarrant) or (972) 233-2233 (Dallas). These hotlines are available 24-hours a day and are free.

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Continued Care:

I understand the following fully:

- After two consecutive missed appointments without 24-hour cancellation notice, the client will be given referrals for further treatment at other counseling facilities and will be considered an inactive patient.

Therapist's Incapacity or Death:

I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me the copies upon request, or to deliver them to a therapist of my choice.

Limits of Confidentiality:

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations:

- child abuse
- abuse of the elderly or disabled
- abuse of patients in mental health facilities
- sexual exploitation
- criminal prosecutions, if a subpoena has been issued.
- child custody cases, if a subpoena has been issued.
- suits in which the mental health of a party is in issue, if a subpoena has been issued.
- situations where therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose (fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing or certifying board.)
- AIDS/HIV infection and possible transmission, if a subpoena has been issued.

If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this consent, you are giving consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you or responsible for providing you mental health care services and payment for those services, and you are also releasing and holding harmless the therapist from any departure from your right of confidentiality that may result.

I have read and understood the above limits to confidentiality.

Signed: _____ **Date:** _____

Duty to Warn:

In the event that the undersigned therapist reasonably believes that I am or my child is a danger, physically or emotionally to myself or another person, I specifically consent for the therapist to contact any person in a position to prevent harm to myself or any other person, including but not limited to the person in danger, and to contact the following persons in addition to medical and law enforcement personnel:

_____ _____

Name **Telephone Number**

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Other Fees

1. If report preparation is requested or required, the time rate charged for therapy sessions will apply.
2. Review of Provided Documents**:** Documents related to history, background information, or school behavior are billed at the rate of $2.00 per minute.
3. Phone Calls: Only emergency phone calls are returned on a regular basis and only during office hours. This fee is billed at $2.00 per minute and will be due at your next session.

   Review of Provided Documents and Phone Calls are not reimbursable by insurance.
4. Professional Fees: Court appearances, depositions, and attorney consultations are $175.00 per hour (including all time involved in preparation, research, parking fees, mileage, travel time to and from the court house and all other expenses incurred in relation to testifying). A retainer deposit of $900.00 is to be paid in advance of (and clear the bank) prior to the court date. If the full amount of the retainer/deposit is not needed to complete the court testifying process, then the remainder of the funds will be refunded. If the costs for the court testifying process exceed the amount of the retainer/deposit, then those fees will be immediately billed to you and are due upon receipt of the invoice.

   The party issuing the subpoena is liable for paying the testifying fees.

   NOTE: Even though you are responsible for the testimony fee, it does not mean that testimony will be solely in your favor. Only the facts of the cases and professional opinion of your counselor can be testified.
5. Returned checks: There is a $35.00 charge on all returned checks.

Signed: _____ **Date:** _____

I understand the following fully:

- After two consecutive missed appointments without 24-hour cancellation notice, the client will be given referrals for further treatment at other counseling facilities and will be considered an inactive patient.

Signed: _____ **Date:** _____

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GUIDELINES FOR CONTINUED CARE

Grievances

I also acknowledge that I may submit a Grievance to the Provider at any time to register a complaint about any aspect of my care. If I am not satisfied with the responses I receive, I may submit the Grievance to the address below:

To report a rules violation by this licensee, contact the following Board:

- Texas Behavioral Health Executive Council

At the following common address:

Texas Behavioral Health Executive Council
George H.W. Bush State Office Bldg.
1801 Congress Ave., Ste. 7.300
Austin, Texas 78701
(512) 305-7700
(800) 821-3205 24-hour, complaint system

Signed: _____ **Date:** _____

Consent to Treatment:

I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through the undersigned therapist at any time.
By signing Professional Agreement and Informed Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Many opportunities have been offered for me to ask questions and seek clarification of anything unclear to me.
This signed copy will be kept in your file; if you want a copy for yourself, please ask and we will be happy to provide one.

_____ _____
Signature of Client or Parent/Guardian **Date**

_____ _____
Therapist **Date**

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E-MAIL AND TEXT MESSAGING INFORMED CONSENT

In order to communicate with you via e-mail or text message, **Therapy Services Texas, LLC** (TST, LLC) needs to ensure you are aware of the confidentiality and other issues that arise when communicating this way. This form is intended to document your understanding of these issues, and by signing, you are stating that you accept and agree to the following:

I understand that all e-mail messages are sent over the Internet, are not secure, and may be read by others. I understand that my e-mail communications with TST, LLC will NOT be encrypted, and therefore TST, LLC CANNOT guarantee the confidentiality or security of any information I send to TST, LLC or that TST, LLC sends to me via e-mail.

I understand that text messages are no more secure than e-mail, and the same conditions apply. I understand that for this reason TST, LLC advises me not to send sensitive information via e-mail or text message. This includes information about current or past symptoms, conditions, or treatment, as well as identifying information such as credit card information.

I hereby give permission for TST, LLC to reply to my messages via e-mail, including with any information that TST, LLC deems appropriate, that would otherwise be considered confidential. I agree that TST, LLC will not be liable for any breach of confidentially that may result from this use of e-mail via the Internet.

I understand that TST, LLC will limit text messages to brief inquiries or responses regarding scheduling.

I understand that TST, LLC may at times e-mail me information about resources that I can use as part of my treatment. I hereby consent to receive such information via e-mail.

I understand that e-mail and text message communication should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. I understand that if I use email or text messages to make or request scheduling changes, it is my responsibility to confirm that TST, LLC has received my communication more than 24 hours before the appointment time that is being changed. If I believe I need a response within 48 hours, I will not use e-mail but will call TST, LLC by telephone. If I do not receive an answer to a routine e-mail or text message within two business days, I understand that I should call TST, LLC by telephone.

I understand that all e-mail and text message communications may be made part of my permanent medical record and would be accessible to anyone given access to those records. I also understand that I may withdraw permission for TST, LLC to communicate with me via e-mail or text message by notifying TST, LLC in writing.

_____ _____

Client Signature (or Guardian/Legal Representative) **Date**

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INFORMED CONSENT TO TELEHEALTH

Telehealth ("Distance Counseling") allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in counseling via telephone or the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Client Name: _____ Clinician: Tiffany A. Derrick, MA, LPC-S, ICPS

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in person counseling. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I understand that while counseling treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of counseling services, such as in person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to **Therapy Services Texas, LLC**.
My signature below indicates that I have read this Agreement and agree to its terms.

_____ _____
Authorized Signature for Client **Date**

- -

ONLY SIGN IF REVOKING CONSENT

This **Consent** may be revoked by the person giving authorization by signing or dating the revocation statement below or through written notice except to the extent that action has been already taken in reliance heron. If not earlier revoked, this consent shall automatically terminate one year after the date signed above without express written revocation.

On this day, _____ of 20_____, I revoke the above *Informed Consent to Telehealth*.

_____ _____
Patient's Signature **Date**

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INFORMED CONSENT FOR TELEPHONIC COUNSELING

This document contains important information for you about counseling sessions via phone with Therapy Services Texas, LLC. This addendum is designed to inform you about what you can expect regarding your participation in telephonic counseling. By signing this document, we enter into an agreement that allows you to attend sessions via phone with me.

Technology

When I provide telephonic counseling sessions, I am calling you from a cellular/mobile phone. You may be speaking to me on a cellular/mobile phone. I will be calling you from my home office and will be the only person in my office during our call. It is best if you are in a private location (for example, a room in your home with the door closed) during our telephonic sessions where you can speak without being overheard or interrupted by others. However, I cannot guarantee the privacy or confidentiality of conversations held via phone, as phone calls can be intercepted either accidentally or intentionally.

If we lose our phone connection during our session, I will call you back immediately on all phone numbers I have for you, starting with the number on which we were speaking. If I am unable to call you back due to a technology problem on my end, please call me at 817-690-5196. If we are unable to reach each other due to technology issues, I will continue to try to call you back every 5 minutes until the end of our session. I will then try to call you back later in the day to reschedule the rest of our session. You may also continue to try to reach me on the number above. It is my policy to continue phone sessions that have been interrupted due to technology issues until you have received your full 45-minute session, even if we need to continue the session at a later time or another day.

As a backup form of communication, should we get disconnected and not be able to get back in touch immediately, you can also send me a message via email at tiffanyderrick@therapyservicestexas.com. If I have email access when you submit the email, I will reply to reschedule our session.

Emergencies and Confidentiality

I will need an emergency contact for you at the beginning of our first phone counseling session. I will also need the address from which you are calling at the beginning of each session. In a situation where we are talking and get disconnected and you are in crisis, you agree to call 911 or go to your local emergency room immediately.

If I have any concerns about your safety at any time during a phone session or at a time when we get disconnected, I will need to break confidentiality and call 911 and/or your emergency contact immediately. Please note that everything in our informed consent that you signed during our first face-to-face session, including all the confidentiality exceptions, still applies during phone sessions.

Emergency Management Plan:

When calling, I can usually return a call or message within 24 hours. If I am unavailable in the event of an emergency, it is imperative you are aware of resources in your area. As a precaution, please identify two (2) nearby emergency hospitals below. In addition, you will need to provide information for an emergency contact person. These all must be completed to participate in Telephonic Counseling.

1. Hospital Name and Location: _____
   Hospital Telephone Number: _____
2. Hospital Name and Location: _____
   Hospital Telephone Number: _____

Emergency Contact Person: _____

Relationship: _____ Phone Number: _____

You may alternatively follow this plan:

1. Call Lifeline at (800) 273-8255 (National Crisis Line)
2. Call 911
3. Go to the emergency room of your choice

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Limitations

I am providing therapeutic services to you as described in the informed consent that you signed during our first face-to- face session. However, it is important to note that there are limitations to telephonic counseling that can affect the quality of phone sessions. These limitations include but are not limited to the following:

- Because the sessions are via phone, I cannot see you, your body language, or your non-verbal reactions to the issues we are discussing.
- Sometimes I may not hear all of what you are saying (due to cellular phone limitations) and may need to ask you to repeat things.

To reduce the effect of these limitations, sometimes I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail that you would during a face-to-face session.

Fees and Cancellations

Payment for phone counseling sessions can be made using PayPal (tiffanyderrick@therapyservicestexas.com) before the date of our phone session. A service charge of 2.9% plus $0.30 will need to be added using PayPal at checkout.

Service	**Individual Counseling Fee**	**Couples Counseling Fee**
Initial Intake and Assessment	$150.00	$175.00
Regular Telephone Sessions:		
45 minutes	$135.00	$150.00 (60 minutes)
1 hour, 15 minutes	$165.00	$190.00
1 hour, 30 minutes	$200.00	$225.00

The policy for cancellations is the same for telephonic sessions as for face-to-face sessions: You are expected to attend all scheduled sessions. If you need to cancel your appointment, please call NO LATER THAN 24 HOURS PRIOR to your scheduled appointment. You will be charged $75.00 for the first appointment cancelled with less than 24 hours' notice. You will be charged $150.00 for the second appointment, and so forth, cancelled with less than 24 hours' notice. I require all clients to pay the cancellation fee before rescheduling the missed session.

No show or cancellation fee without 24 hours' notice:

1st time	$75.00
2nd time	$150.00

Consent to Participate in Telephonic Sessions

By signing below, you agree that you have read all of the above sections of the telephonic counseling informed consent addendum and that you understand the limitations associated with participating in telephonic counseling sessions and consent to attend sessions under the terms described in this document.

_____	_____	_____
Printed Name of Client	**Signature of Client**	**Date**

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ADULT INFORMATION FORM

(Please Print)

Date: ____/____/**20____**

Client Name: _____ M/F Date of birth: _____

Address: _____ City/State: _____,_____ Zip:_____

Phone: Home (____) _____ Work (____) _____ Cell: (____) _____

May we leave a message for you at home? ☐ Yes ☐ No Work? ☐ Yes ☐ No

E-mail address: _____

☐ Employed ☐ Student

Do you want your counselor to incorporate faith/spiritual issues into your counseling? ☐ Yes ☐ No

Name of church attending: _____

School (if student): _____ Years of Education _____

Employer: _____ Years with employer: _____

Who referred you to us? _____

Reason for coming in: _____

MEDICAL HISTORY

Primary Care Physician: _____ Phone #: _____

Previous Treatment: ☐ Yes ☐ No

Prescription medications currently taking:

1) _____Dosage/Freq. _____Start Date _____Purpose _____
2) _____Dosage/Freq. _____Start Date _____Purpose _____
3) _____Dosage/Freq. _____Start Date _____Purpose _____

Prescribed by_____
Date of last medical evaluation _____ Date of next appt._____

Please list any over-the-counter medications you currently use:

1) _____Dosage/Freq. _____Start Date _____Purpose _____
2) _____Dosage/Freq. _____Start Date _____Purpose _____
3) _____Dosage/Freq. _____Start Date _____Purpose _____

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Have you ever been hospitalized? ☐ Yes ☐ No

Hospital	Month/Year	Reason

How much exercise are you getting? _____

How many hours are you sleeping? _____

Have you had any changes in eating habits? ☐ Yes ☐ NO
Describe:
_____
_____

PSYCHIATRIC HISTORY

Have you ever received psychiatric or psychological treatment before? ☐ Yes ☐ No

What type of care did you receive? ☐ Inpatient ☐ Outpatient ☐ Both
Are you currently seeing a Psychiatrist? ☐ Yes ☐ No

Name: _____ Phone: _____

Outpatient: Therapist _____ Time Frame: _____

Inpatient: Where _____ Month/Year: _____

Do you have any close relatives (father, mother, brother, sister) who have experienced depression or other emotional problems?
Please list: _____
_____

Describe any other health problems or important medical history about yourself or close family members, including chronic ailments:
_____
_____
_____

Please circle any of the following that describe how you have been feeling lately:

sad	frightened	ashamed	worthless	confused	hopeless	anxious	guilty	aggressive
tearful	extreme ups & downs		helpless	depressed	angry	resentful	irritable	jealous

Describe any other feelings you have had:
_____
_____
_____

Have you ever considered suicide in connection to your current problems? ☐ Yes ☐ No

If so, please give a brief description with dates:

Description	Dates

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Have you ever considered suicide in the past? ☐ Yes ☐ No

Have you attempted suicide recently or in the past? ☐ Yes ☐ No

If so, please give a brief description with dates:

Description	Dates
_____	_____
_____	_____

Level of functioning: List or describe any current impediments or problems in daily psychological, social or occupational functioning, i.e. isolation from friends/family, significant difficulty getting to work or making yourself do daily tasks, severe financial strain, recent divorce, loss or separation from family or friend, problems with supervisor, etc.

_____
_____
_____

Thoughts: Please check any of the following that apply to you:

☐ I sometimes hear voices even though no one nearby is talking to me.
☐ I sometimes feel that forces outside of me control me.
☐ I sometimes feel that other people control my thoughts.
☐ I sometimes have the same thought over and over and cannot control it.
☐ I sometimes feel that someone is out to hurt me or do something against me.
☐ I am sometimes unable to control my behavior. Please explain: _____

_____
_____

Please check coping skills that you are currently using: ☐ exercise ☐ relaxation ☐ prayer/meditation

☐ Music ☐ Reading ☐ Hobby: _____

☐ Church ☐ Organization/clubs ☐ Volunteering: _____

Please describe any spiritual orientation or belief (i.e. Christian, attend Catholic Church weekly):

_____
_____
_____
_____

LEGAL HISTORY

Do you have any pending legal charges? ☐ Yes ☐ No _____

Have you ever been convicted of anything other than a misdemeanor? ☐ Yes ☐ No _____

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SUBSTANCE ABUSE

Do you drink coffee? ☐ Yes ☐ No

Do you smoke cigarettes? ☐ Yes (___cigarettes per day) ☐ NO

Do you drink alcohol? ☐ Yes ☐ No
If yes, please list:

Type of Alcohol	How much?	How often?
_____	_____	_____
_____	_____	_____

Do you use recreational drugs? ☐ Yes ☐ No
If yes, please list:

Type of Drugs	How much?	How often?
_____	_____	_____
_____	_____	_____

EDUCATION

Please list any schools or programs you have attended:

	Name	Years	Year Graduated
High School:	_____	_____	_____
College:	_____	_____	_____
Other:	_____	_____	_____

EMPLOYMENT

Employer: _____ Days/Hours per Week: _____

How would you describe your relationship with your employer?

_____
_____
_____

How would you describe your relationship with your work peers?

_____
_____
_____

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FAMILY HISTORY

Mother: ☐ Living ☐ Deceased ☐ Married ☐ Divorced ☐ Remarried (___# of times)

Describe relationship with mother while growing up:

_____
_____
_____

Describe current relationship with mother:

_____
_____
_____

Father: ☐ Living ☐ Deceased ☐ Married ☐ Divorced ☐ Remarried (___# of times)

Describe relationship with father while growing up:

_____
_____
_____

Describe current relationship with father:

_____
_____
_____

Where do your parents currently live? Mother: _____ Father: _____

Please list your brothers and sisters:

Name	Age	Natural/Step	Lives Where?	Relationship

Current status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Living Together

If married, how long have you been married? _____ Spouses Name: _____

How many times have you been married? _____ If living with someone, how long have you lived together? _____

Please list your children:

Name	Age	Natural/Step	Lives With	Relationship

Others living in the home with you:

Name	Relationship	Age	Grade/Occupation

Therapy Services Texas, LLC

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Website: https://www.therapyservicestexas.com

ADULT CHECKLIST OF CONCERNS

Name: _____ Date: _____

Please mark all of the items below that apply and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ☐ I have no problem or concern being here
- ☐ Abuse-physical, sexual, emotional, neglect
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Children, child management, child care, parenting
- ☐ Codependence
- ☐ Compulsions
- ☐ Confusion
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use – prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems-overeating, under eating, appetite, vomiting (see also "Weight and diet issues")
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses
- ☐ Guilt
- ☐ Headaches, pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Inferiority feeling
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits
- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems
- ☐ Risky behavior
- ☐ School problems (see also "Career concerns")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems – too much, too little, insomnia, nightmare
- ☐ Smoking and tobacco use
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Work problems, employment, workaholic/overworking, can't keep a job

Any other concerns or issues:

_____

_____

Please look back over the concerns you have checked off and choose the one that you most want help with.
It is: _____

_____

This is a strictly confidential client medical record. Redisclosure or transfer is expressly prohibited by law.

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CONSENT TO RELEASE INFORMATION

I, _____ DOB _____
(Client's Name)

_____
Address

_____
City State Zip

DO HEREBY AUTHORIZE _____ OR HIS/HER DESIGNATED AGENT

TO **RELEASE INFORMATION TO** or **RECEIVE INFORMATION FROM** THE FOLLOWING PARTIES:

Name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

PLEASE CHECK THE SECTIONS OF THE RECORD NEEDED:

❑ Discharge Summary	❑ Psychological Evaluation	❑ Disability Assessment Information
❑ School Reports	❑ Psychosocial Assessment	❑ Medical Information
❑ Speech/Language/Hearing Assessment	❑ Psychiatric Assessment	
❑ Verbal Communication	❑ Master Treatment Plan	
❑ Other_____	❑ Therapy Notes	

This disclosure of verbal and/or written information authorized here is made for the following purposes(s).

_____

_____ _____
Patient's Signature **Date**

_____ _____
Witness **Date**

ONLY SIGN IF REVOKING CONSENT

This **Consent** may be revoked by the person giving authorization by signing or dating the revocation statement below or through written notice except to the extent that action has been already taken in reliance heron. If not earlier revoked, this consent shall automatically terminate one year after the date signed above without express written revocation.

On this day, _____ of 20_____, I revoke the above Consent to Release Information.

_____ _____
Patient's Signature **Date**

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CONSENT FOR RELEASE OF MEDICAL INFORMATION FOR GUARDIAN/LEGAL REPRESENTATIVE

I, _____ for _____ DOB _____
(Guardian's Legal Representative's Name) Client's Name

_____
Address

_____
City State Zip

DO HEREBY AUTHORIZE _____ OR HIS/HER DESIGNATED AGENT

TO **RELEASE INFORMATION TO** or **RECEIVE INFORMATION FROM** THE FOLLOWING PARTIES:

Name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

CONCERNING:

- ❑ Diagnosis
- ❑ Psychological Evaluation
- ❑ Psychosocial Assessment
- ❑ Summary of Services
- ❑ Attendance & Progress
- ❑ Disability Assessment Information
- ❑ Medical Information (Specify): _____
- ❑ Other (Specify): _____

This disclosure of verbal and/or written information authorized here is made for the following purposes(s).

_____

_____ _____
Guardian/Legal Representative **Date**

_____ _____
Patient's Signature **Date**

_____ _____
Witness **Date**

ONLY SIGN IF REVOKING CONSENT

This **Consent** may be revoked by the person giving authorization by signing or dating the revocation statement below or through written notice except to the extent that action has been already taken in reliance heron. If not earlier revoked, this consent shall automatically terminate one year after the date signed above without express written revocation.

On this day, _____ of 20_____, I revoke the above Consent to Release Information.

_____ _____
Patient's Signature **Date**

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NOTICE OF PRIVACY PRACTICES

The effective date of this Notice is April 14, 2003.

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

Your health record contains personal information about you and your health. This information about you may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the ***LPC Code of Ethics***. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, review services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Child Abuse and Neglect: We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings: We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients: We may disclose PHI regarding deceased patients as mandated by state law or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies: We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care: We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

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Health Oversight: If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control. Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises. Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Safety: We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the professional counselor licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Your Rights Regarding Your Phi

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at **THERAPY SERVICES TEXAS, LLC, 3509 HULEN STREET, SUITE 100, FORT WORTH, TEXAS 76107.**

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

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COMPLAINTS

Our Responsibilities

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a website that provides information about our patient/customer services or benefits, the new notice will be posted on that website.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) most uses and disclosures of psychotherapy notes (ii) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of your health information; and (iv) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

For More Information or to Report A Problem

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Tiffany A. Derrick, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with Therapy Services, Texas, LLC, or with the Secretary of the Department of Health and Human Services or Texas Attorney General's office. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services Office of the Secretary 200 Independence Avenue, S.W. Washington, D.C. 20201 Tel: (202) 619-0257 Toll Free: 1-877-696-6775 http://www.hhs.gov/grants/contracts/index.html	**Office of the Texas Attorney General Consumer Protection Division** PO Box 12548 Austin, TX 78711-2548 Tel: (512) 463-2100 Toll Free: 1-800-252-8011 https://www.texasattorneygeneral.gov/consumer-protection/file-consumer-complaint	**Therapy Services Texas, LLC** Tiffany A. Derrick, LPC-S, ICPS Privacy Officer 3509 Hulen Street, Suite 100 Fort Worth, TX 76107 Tel: (817) 690-5196

Notice of Privacy Practices Availability

You may obtain a copy upon request, and the notice will be maintained on the organization's website for downloading.

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ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I understand I have a right to review **Therapy Services Texas, LLC**, henceforth referred to as **TST, LLC**, Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (referred to as **PHI**) that will occur in my treatment, payment of my bills and the rights I have regarding my **PHI**. I consent to the use or disclosure of my **PHI** for these purposes.

I understand I have the right to request a restriction as to how my **PHI** is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **TST, LLC** is not required to agree to the restrictions that I may request. However, if **TST, LLC** agrees to a restriction that I request, the restriction is binding on **TST, LLC** and my counselor. I also understand that if these restrictions limit the ability of my insurance to pay, I will be held responsible for the entire fee up front.

I have the right to revoke this consent, in writing, at any time, except to the extent that my counselor or **TST, LLC** has already taken action based on this consent.

The Notice of Privacy Practices for **TST, LLC** is provided upon request. **TST, LLC** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

_____

Printed Name of Client

_____

Signature of Client or Personal Representative

_____

Date

Communication Authorization and Release of Information to Family Members

Do we, **Therapy Services Texas, LLC**, have permission to:

- Leave a message on your home answering machine regarding an appointment? ❒ **YES** ❒ **NO**
- Contact you at work regarding appointment changes, etc.? ❒ **YES** ❒ **NO**
- Contact you by email regarding your appointment or bill? ❒ **YES** ❒ **NO**
- Discuss your appointment times with your spouse/parent/partner? ❒ **YES** ❒ **NO**

I acknowledge that confidentiality may not be maintained if text, e-mail or a cell phone is used pertaining to my Protected Health Information.

_____

Printed Name of Client

_____

Signature of Client

_____

Date

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CLIENT RIGHTS

You, your family, and your friends can be assured that the staff of **Therapy Services Texas, LLC** want to protect your rights. We can to be sure that you receive all of your legal rights and that you are always treated with dignity and respect. Therefore, the purpose of the Client rights statement is to inform you of your rights and obligations to **Therapy Services Texas, LLC** as well as ours to you, in order to provide you the most effective treatment possible according to your needs.

1. You have the right to considerate and respectful treatment, regardless of age, race, sex, national origin, citizenship or legal status.
2. You have the right to expect our staff to send you or refer you to other places for treatment if we do not, or cannot, offer you the services you need.
3. You have the right to be treated as a person capable of managing your own affairs if you are eighteen (18) years of age or older, unless a court orders otherwise.
4. You have the right to be fully advised of and question the fees charged by **Therapy Services Texas, LLC** at the time of your intake process and throughout your services.
5. You have the right to know that your records are treated in a confidential manner and cannot be released without your consent, except under court order of law. Your records and private conversations with our staff will be kept in strict confidence, even after you stop coming here or services.
6. You have the right to get complete and current information concerning your treatment in terms which you can understand. You have the right to know the name, title, and professional qualifications of any person participating in your treatment.
7. You have the right to refuse treatment, except when limited by court order, law or rule and to be informed of the consequences of your refusal.
8. You have the right to a written Individual Treatment Plan, as well as the right to participate in the preparation of the plan. In addition, you have the right to participate in the review and any changes to be made.
9. Whenever we ask you (or your parent or guardian) to make a decision about something which affects you, you have the right to make your decision without force or pressure from us.
10. No one may take pictures of you or tape record in any program of **Therapy Services Texas, LLC** unless you agree in writing.
11. You have the right to speak up if you do not like your services, or if you think someone is taking away your rights.

Your Responsibilities For Care Are:

1. Tell your counselor/therapist what you need.
2. Be on time for your appointments; call if you cannot keep your appointment with 24-hour notice.
3. Do not endanger others with your behavior.
4. Follow the rules of conduct required in therapy.
5. Do not use nonprescription drugs (including alcohol) before or during your visit.
6. Cooperate to your fullest.

I have received a complete explanation in simple, non-technical language of my rights guaranteed to me as a client of TST, LLC, assigned to Tiffany A. Derrick, LPC-S, ICPS at **Therapy Services Texas, LLC.**

Client's Signature: _____ **Date:** _____

Staff Signature/Title: _____ **Date:** _____