Crossroads Child & Family Counseling, PLLC

Rachael Wright, MA, LPC, RPT

3550 Parkwood Blvd. Suite 401 Frisco, TX 75034

GENERAL INTAKE INFORMATION

Name: ____ Date: _____________________

Date of birth: _________________ Age:__________ Gender: M F

Home Address: ____ _______________ ____________
(Street address) *(City)* *(Zip)*

Home Phone#___________________ Cell Phone#___________________ Work Phone#_________________

May we communicate by mail at this address?

Contact you at Work? Yes No Contact you at home? Yes No Contact you on cell phone? Yes No

E:mail address ____

May I correspond with you via e:mail at the specified above address? Yes No

Occupation ______________________________ Length of time at this Job? _______________________

Work days and hours ________________ Would you describe your work as stressful? Yes No

Referred by: ____

Activities and/or hobbies you enjoy ____

History of learning, emotional, or behavioral problems? Yes No

(If yes, please explain) ____

History of alcohol/drug/substance abuse? Yes No

(If yes, please explain) ____

History of domestic violence? Yes No (if yes, please explain)

____

History of criminal activity? Yes No

(If yes, please explain) ____

Emergency Contact Name____

Relationship to you: ______________________ Phone # ______________________

(Your signature on page 4 indicates consent to contact this person in the rare case an emergency should occur)

General Health ___ Excellent ___ Good ___ Fair ___ Poor Date of Last Physical ____________________

Primary Care Physician: ____________________________________ Phone# ________________________

Address: ____ __________________ __________
Street City Zip

Current Diagnosis, or Medical Concerns: ____

Psychiatrist: ____ Phone# ________________________

Address: ____ __________________ __________
Street City Zip

Current Diagnosis, or Mental Health Concerns: ____

List all current medications you are taking

Medication _____________________________________ Dosage ______________________________

Medication ______________________________ Dosage ________________________
Medication ______________________________ Dosage ________________________

Past Counseling History:

Date	Dates of Service	Agency and Therapist Providing Service

*Are you currently in counseling elsewhere? Yes No
If yes, we require written confirmation of the counselor's consent for treatment at Crossroads Child & Family Counseling.

Have you ever been hospitalized for mental health concerns? Yes No Date: ____________________

Briefly describe why you are seeking counseling? ______________________________________

Present Household: (*Anyone currently living with you)*

Name	*Age*	*Gender*	*Relationship*

Marital Status: *Indicate all that apply and duration of each. Example, 1980 – 2001*

Married ____________ *Separated* ____________ *Divorced* ____________ *Widowed* ____________
Married ____________ *Separated* ____________ *Divorced* ____________ *Widowed* ____________
Married ____________ *Separated* ____________ *Divorced* ____________ *Widowed* ____________

If divorced, circle the number which best describes your relationship with you ex-spouse.

Hostile Frustrating Friendly

1-----------------------------2-----------------------------3-----------------------------4-----------------------------5

Are you currently involved in a custody dispute? Yes No

Family of Origin:

Name	*Age*	*Gender*	*Relationship*

Family of Origin Atmosphere:

Describe your relationship with your parents as a young child: ____

____

____

Please give three adjectives to describe your relationship with your mother as a young child:

________________________ ________________________ ________________________

Please give three adjectives to describe your relationship with your father as a young child:

________________________ ________________________ ________________________

Which parent did you feel closest to, and why? ____

____

When you were upset as a child, what did you do? ____

____

In general, how do you think your overall experiences with your parents have affected your adult personality?

____

____

Please summarize your current relationship with your parents. ____

Please summarize your religious/spiritual beliefs and the importance they play in your life: ____________________

____

Please summarize any major life changing events you have experienced which have positively or negatively affected you: ____

Current Trauma/Stressors (Check all that apply)

_____ Divorce/Separation
_____ Relationship difficulties
_____ Victim of trauma
_____ Family Stressors
_____ Death of a significant person
_____ Incarcerated family member
______ Health problems
______ Work related problems
______ Other (Please explain) ____

Interpersonal Problems (Check all that apply)

___ Aggressive behavior ___ Temper outbursts ___ Boundary Issues
___ Alcohol or drug abuse ___ Sexual acting-out ___ Social anxiety

___ Other (Please explain) ____

Current struggles in your life that you would like to address in counseling. (Check all that apply)

☆ Place a star by the most significant issue.

Issues Related to Abuse

___ Current or past physical abuse
___ Current or past sexual abuse
___ Current or past emotional abuse
___ Current or past neglect
___ History of abandonment/rejection
___ History of family domestic violence

Career/Academic Issues

___ Colleague/Cohort problems
___ Work performance
___ Failing grades
___ Career dissatisfaction

Mood Related Concerns

___ Disturbing Memories
___ Sadness/Depression
___ Suicidal thoughts
___ Feelings of guilt & shame
___ Excessive worrying
___ Estranged relationships

Family Relationship Concerns

___ Adjusting to family changes
___ Parenting/Discipline concerns
___ Parent/child relationship
___ Divorce
___ Separation
___ Religious/Spiritual concerns

Behavioral Concerns

___ Aggression toward others
___ Drug/alcohol use
___ Hyperactive/Impulsivity
___ Betraying relationships
___ Cutting
___ Engaging in high-risk behaviors

Other Concerns

___ Sexual identity questioning
___ Appetite eating concerns
___ Sleep problems
___ Stress management
___ ADHD/ADD management
___ Loneliness

Other Struggles you would like to address ___________________________________

Please summarize your current goals for counseling: ___________________________

____

Client Signature ____________________________________ Date: ______________

Rachael Wright, MA, LPC, RPT

Crossroads Child & Family Counseling, PLLC

3550 Parkwood Blvd. Suite 401 Frisco, Texas 75034

PROFESSIONAL DISCLOSURE STATEMENT

Qualifications: Rachael is a Licensed Professional Counselor licensed by the Texas State Board of Examiners of Professional Counselors. She is a member of the Association for Play Therapy. Her areas of expertise include adult, and child/adolescent therapy. In addition to individual therapy, Rachael has experience providing play therapy groups and parenting groups called Child Parent Relationship Training.

Experience: In 2005, Rachael graduated with a double major from Hardin Simmons University obtaining a Bachelor of Behavioral Science in Psychology and Bachelor of Arts in Studio Art. In 2009, she graduated from Dallas Baptist University with a Master of Arts in Counseling. She has counseling experience working in community and private practice settings leading groups, doing crisis intervention, and over seeing a play therapy program. She also has experience in many forms of art that she incorporates into counseling to improve self expression and insight. She has experience working with adults and children with a variety of concerns including: depression, anxiety, family conflict, low academic performance, ADHD, Autism spectrum disorder, and divorce.

Nature of Counseling: Rachael's counseling theory is centered on Carl Roger's client centered theory and attachment theory. She believes that we all possess the inner resources to manage life's events, but for different reasons we are not able to access or realize them. When an individual experiences a place of safety where they can express thoughts and feelings openly they will able to find healing and their inner resources. In counseling she works collaboratively with the client to create treatment goals and based on those goals incorporates skill building and expressive activities. Skill building and expressive activities can aid in relaxation, anger management, depression, communication, parenting, and emotional expression.

Informed Consent

Emergency/Crisis: Please know that Crossroads Child & Family Counseling, PLLC does not provide a 24-hour crisis counseling service. Should you experience an emergency necessitating immediate mental health attention, call 9-1-1 or go to the nearest emergency room for assistance.

Counseling Relationship: During the course of counseling, you and/or your child will meet with Rachael for approximately 45 minute sessions. Although sessions may be psychologically intimate, the relationship between client and therapist is professional. Please do not ask me to relate to you in any way other than the professional context of counseling sessions.

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discounting counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a process of personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Clients Rights

Some clients need only a few counseling sessions to achieve their goals; others may require months or even years. As a client, you are in complete control and may end our counseling relationship at any time, though I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any counseling techniques or suggestions that you believe might be harmful.
You are assured that counseling services will be rendered in a professional manner consistent with accepted legal and ethical standards as stipulated by the Texas State Board of Examiners of Licensed

Professional Counselors and the HIPAA security and privacy rules. If at any time, for any reason you are dissatisfied with the services at Crossroad Child & Family Counseling PLLC, please let me know so that existing issues can be worked through. If someone is not available to resolve your concerns, you may report your complaint.

Referrals: Should you and/or Rachael believe that a referral is needed; you will be provided with some alternatives, including programs and/or people who may be available to assist you. Also, should you miss two appointments concurrently for whatever reason; a referral will also be provided. You will be responsible for contacting and evaluating those referrals and/or alternatives.

Fees: In return for a fee of **$120** per session, Crossroads Child & Family Counseling, PLLC agrees to provide counseling services for you. The original intake session is **$150.00**. The fee for each session will be due at the conclusion of each session.

The rate for all related counseling services, including but not limited to, time incurred due to phone calls over 5 minutes, medical concerns, psychiatric concerns, home and family social studies, child protective service cases, adoption and foster care, issues of divorce, child custody, attorney consultations, educational concerns, behavioral concerns, ARD meetings, classroom observations, interactions with insurance providers, etc., will be billed at **$120** per hour in 15 minute increments. In the case of off-site services, fee includes travel time to and from Crossroads Child & Family PLLC. Checks are payable to, "Crossroads Child & Family Counseling, PLLC." You may also pay by M/C or Visa.

CANCELLATION POLICY: In the event you are unable to keep an appointment, please give notification of **24 hours** or more. **IF A CANCELLATION OCCURS WITHOUT A 24 HOUR NOTICE OR YOU FAIL TO KEEP YOUR SCHEDULED APPOINTMENT, A REGULAR SESSION FEE WILL BE BILLED TO YOUR CREDIT CARD OR BILLED TO YOU.** All returned checks will incur a **$25.00** return-check fee. If you are absent two weeks in a row without contacting me, you will be provided with other referral sources for further counseling. Likewise, if you are absent three sessions in a row, even with contact, you will provided with other referral sources for a continuation of counseling at a different facility. If you do, at any time, intend to discontinue counseling, please inform me as soon as possible so that other clients can be serviced.

Records and Confidentiality: Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated or permitted 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 treatment facilities; sexual exploitation; AIDS/HIV and other communicable disease infection and possible transmission; court orders, criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, protect, notify or disclose; sexual exploitation by a mental health professional or member of the clergy, fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; the filing of a complaint with a licensing board or other state or federal regulatory authority; to regulatory authorities in connection with their compliance or investigatory responsibilities; to employees or agents of the practice for operational purposes, to a supervisor if the therapist is under supervision and for treatment consultations with other mental health professional when deemed necessary by the therapist. **FOR FURTHER INFORMATION REVIEW THE NOTICE OF PRIVACY PRACTICES FURNISHED TO YOU BY YOUR THERAPIST IN CONJUNCTION WITH THIS CLIENT INFORMATION AND CONSENT DOCUMENT**. By signing this Intake and consent form below you acknowledge receipt of a copy of the Notice of Privacy Practices. 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 information and consent form below, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated or permitted by law, with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned therapist for any departure from your right of confidentiality that may result.

Duty to Warn

In the event that the undersigned therapist reasonably believes that you are a danger, physically or emotionally, to yourself or another person, by singing this information and consent form below, you specifically consent for the therapist to warn the person in danger and to contact any person in position to prevent harm to yourself or another person, in addition to medical and law enforcement personnel, and the following persons:

NAME	**TELEPHONE NUMBER:**
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

This information is to be provided at your request for use by said persons **only** to prevent harm to yourself or another person. This authorization shall expire upon the termination of your therapy with the undersigned therapist.You acknowledge that you have the right to revoke this authorization in writing at any time to the extent the undersigned therapist has not taken action in reliance on this authorization. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned therapist that you have received and reviewed.
You acknowledge that you have been advised by the undersigned therapist of the potential of the redisclosure of your protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule. You further acknowledge that the treatment provided to you by the undersigned therapist was conditioned on you providing this authorization.

Court: It is in your best interest to know that conducting expert witness/testimonial service is not in my area of interest or expertise. I do not agree to serve as an expert witness or to provide testimonial services for you, and you agree not to cause my services to be used in this way. If you are seeking counseling for court or court-related purposes or motivations, I will provide you with alternative appropriate referral sources. Should you, your attorney, your spouse or ex-spouses attorney ,subpoena me or your client file as a factual case witness, or involve me in court-related proceedings, you agree to pay **$300.00** for every hour of my time involved, including case preparation, travel, witness time, and any wait time related to a court-related process. You further agree to pay a retainer fee of **$2,400.00** at the time a subpoena is served, to be applied toward these charges. If a subpoena is issued for me, it will be turned over to an attorney, and I will consult with an attorney as necessary at your expense. A bill will be rendered to you for immediate payment when a subpoena is issued.
If you have a suspicion that your case will be going to court, or you will need therapist testimony, please let me know before a counseling relationship is established, and appropriate referral sources will be provided to you.
Please note: 24 hour advanced notice is required if a cancellation occurs related to a court process, including dismissal of case. If a 24-hour notification is not made, a fee of **$2,400** will be billed. (8 hrs. @ $300 per hour)

Email and Text Messages: The undersigned therapist uses and responds to email and text messages only to arrange or modify appointments. Please do not send emails related to treatment or therapy sessions as electronic communications are not completely secure and confidential. **Any therapy related questions or issues will not be addressed by the therapist in any electronic communication but will be dealt with during the next therapy session.** Any electronic transmissions of information by you are retained in the logs of your service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. You should know that any emails or texts received from you and any responses sent will become part of the therapy record.

Social Media: Your therapist does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the therapist and the client. It can blur the boundaries of the professional relationship and are not permitted. Any attempt by a client to surreptitiously gain access to the therapist's personal site(s) will be cause for termination of the therapy.

Therapist's Incapacity or Death: You acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of your's and child's file and records. By signing this information and consent form below, you give consent to allowing another licensed mental health professional selected by the undersigned therapist to take possession of each file and records and provide you with copies upon request, or to deliver them to a therapist of your choice. The undersigned therapist will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

or Audio Recordings: You acknowledge and, by signing this information and consent form below, agree that neither you or the undersigned therapist will record any part of your sessions unless you and the therapist mutually agree in writing that the session may be recorded. You further acknowledge that the undersigned therapist objects to you recording any portion of your sessions with out the therapist's written consent.

Defamation: By signing this intake and consent form below you agree that you will not make defamatory comments about the undersigned therapist to others or to post defamatory commentary about the therapist on any website or social media site. In the event that defamatory remarks about the therapist are made by you, or others acting in concert with you, you further consent by signing this intake and consent form below to allowing the therapist to use confidential information necessary to rebut or defend against, or prosecute claims for, the defamation.

By my signature below, I acknowledge reading and understanding this document, and that any questions I had about this document were answered to my satisfaction, and that I was furnished a copy of this document. My signature below acknowledges my agreement with and commitment to comply with all its terms and requirements including the financial obligations and cancellation policy, and my consent for Rachael Wright MA, LPC, RPT to provide counseling to me.

____ ____________________

Client / Guardian Signature Date

____ ____________________

Counselors Signature Date

Client Copy

Rachael Wright, MA, LPC, RPT
Crossroads Child & Family Counseling, PLLC
3550 Parkwood Blvd. Suite 401 Frisco, Texas 75034

PROFESSIONAL DISCLOSURE STATEMENT

By my signature below, I acknowledge reading and understanding this document, and that any questions I had about this document were answered to my satisfaction, and that I was furnished a copy of this document. My signature below acknowledges my agreement with and commitment to comply with all its terms and requirements including the financial obligations and cancellation policy, and my consent for Rachael Wright MA, LPC, RPT to provide counseling to me.

____ ____________________
Client / Guardian Signature Date

____ ____________________
Counselors Signature Date

Updated Jan. 2015 Rachael Wright's Copy

Rachael Wright, MA, LPC, RPT

Crossroads Child & Family Counseling, PLLC

3550 Parkwood Blvd. Suite 401 Frisco, TX 75034

COURT TESTIMONY AGREEMENT

_____ I am seeking counseling for court testimony or court involvement on behalf of Rachael Wright, MA, LPC, RPT

_____ I am NOT seeking counseling for court testimony or court involvement on behalf of Rachael Wright, MA. LPC, RPT

_____ I have been requested by Rachael Wright, MA. LPC, RPT to provide the most recent court papers concerning my child.

It is in your best interest to know that conducting expert witness/testimonial service is not in my area of interest or expertise. I do not agree to serve as an expert witness or to provide testimonial services for you, and you agree not to cause my services to be used in this way. If you are seeking counseling for court or court-related purposes or motivations, I will provide you with alternative appropriate referral sources. Should you, your attorney, your spouse or ex-spouses attorney, or any other person subpoena me or your client file as a factual case witness, or involve me in court-related proceedings, you agree to pay me $300.00 for every hour of my time involved, including case preparation, travel, witness time, and any wait time related to a court-related process. You further agree to pay a retainer fee of $2,400.00 at the time a subpoena is served, to be applied toward these charges. If a subpoena is issued for me, it will be turned over to an attorney, and I will consult with an attorney as necessary at your expense. A bill will be rendered to you for immediate payment when a subpoena is issued.
If you have a suspicion that your case will be going to court, or you will need therapist testimony, please let me know before a counseling relationship is established, and appropriate referral sources will be provided to you.
Please note: 24 hour advanced notice is required if a cancellation occurs related to a court process, including dismissal of case. If a 24-hour notification is not made, a fee of $2,400 will be billed. (8 hrs. @ $300 per hour)

By your signature below, you are indicating that you read and understood this document, or that any questions you had about this document were answered to your satisfaction.

____ ____________________
Client's Signature Date

____ ____________________
Rachael Wright, MA, LPC, RPT Date

Rachael Wright, MA, LPC, RPT

Crossroads Child & Family Counseling, PLLC

3550 Parkwood Blvd. Suite 401 Frisco, TX 75034 940-300-1706

CONSENT FOR DISCLOSURE OF INFORMATION

I, ___________________________, hereby provide authorization for Rachael Wright, MA., LPC, RPT to obtain and /or provide the following information:

____

____

____

To / From **To / From**

The following parties/agencies

______________________________ *Agency Name*	Crossroads Child & Family Counseling, PLLC
______________________________ *Contact Name*	Rachael Wright MA, LPC, RPT
______________________________ *Address*	3550 Parkwood Blvd. Suite 401
______________________________ *City, State, Zip Code*	Frisco, TX 75034
______________________________ *Fax #*	
______________________________ *Phone #*	

I acknowledge that I have the right to revoke this authorization in writing at any time to the extent a provider has not taken action in reliance on this authorization. I acknowledge the potential of redisclosure of my protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule.

I further acknowledge that no treatment has been provided to me conditioned on my signing this authorization.

____ ____________________

Client *Date*

____ ____________________

Parent/Guardian *Date*

____ ____________________

Rachael Wright, MA., LPC, RPT *Date*

Crossroads Child & Family Counseling, PLLC

CREDIT CARD AUTHORIZATION FORM

Authorizing form granting Crossroads Child & Family Counseling PLLC permission to process credit/debit charges

The security of your personal information is extremely important. Crossroads Child & Family Counseling, PLLC is committed to protecting the security and privacy of any personal information you provide, including any financial information. Please inquire of any questions concerning this authorization.

Client Names 1.________________________2.________________________

3.________________________4.________________________

Please read all below:
Acceptable forms of payment are: cash, check, debit card, or credit card

My initials below indicate the following:

______ **Initial here if you would like to pay session fees with your credit or debit card**.

Initialing here indicates you authorize Crossroads Child & Family Counseling, PLLC to be compensated for missed appointments of which the client/s named above did now show up for or cancel at least 24 hours before the time of the appointment. Missed appointment fees are the same for all clients at the standard rate of $120 per session.

______ **Initial here if you would like to pay session fees by check**

Please complete all of the information below

Type of card (circle) **VISA** **MC** **AMX**

Exact name on card ____

Number on card ____

Expiration Date ____________________CVC________________

Billing address ____

____

City State Zip Code

Without my debit/credit card, I authorize Crossroads Child and Family Counseling, PLLC to use my credit/debit card number provided below to process charges/fees assigned to any named individual listed above.

My signature below acknowledges my agreement with and commitment to comply with the terms and requirements of the financial obligations and cancelation policy.

Signature ________________________________ Date ________________

Notice of Privacy Practices of Crossroads Child & Family Counseling, PLLC

Effective January 1, 2015

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

I am required by law to maintain the privacy of your protected health information (PHI) and to provide you with notice of your privacy rights and my legal duties and privacy practices with respect to your PHI. I am required to abide by the terms of this notice with respect to your PHI but reserve the right to change the terms of this notice and make the new notice provisions effective for all PHI that I maintain. I will provide you with a copy of the revised notice sent by regular mail to the last address you have provided to me for this communication purpose.

UNDERSTANDING YOUR PERSONAL HEALTH INFORMATION

Each time you visit a hospital, physician, mental health professional or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, in the case of a mental health professional, psychotherapy notes, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer can verify that services billed were actually provided a tool in educating heath professionals.
- A source of data for medical research.
- A source of information for public health officials charged with improving the health of the nation a source of data for facility planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy.
- Better understand who, what, when, where, and why others may access your health information.
- Make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of my practice, the facility that compiled it, the information belongs to you. You have the following privacy rights:

1. The right to request restrictions on the use and disclosure of your PHI to carry out treatment, payment or health care operations.
   You should note that I am not required to agree to be bound by any restrictions that you request but am bound by each restriction that I do agree to.
2. In connection with any patient directory, the right to request restrictions on the use and disclosure of your name, location at this treatment facility, description of your condition and your religious affiliation. (I do not maintain a patient directory.)
3. To receive confidential communication of your PHI unless I determine that such disclosure would be harmful to you.
4. To inspect and copy your PHI unless I determine in the exercise of my professional judgment that the access requested is reasonably likely to endanger your life or physical safety (Note: if state law allows, “emotional safety” may be included as well) or that of another person.
   You may request copies of your PHI by providing me with a written request for such copies. I will provide you with copies within ten (10) business days of your request at my office. You will be charged $.25 for each page copied and you will be expected to pay for the copies at the time you pick them up.
5. To amend your PHI upon your written request to me setting forth your reasons for the requested amendment. I have the right to deny the request if the information is complete or has been created by another entity.
   I am required to act on your request to amend your PHI within sixty (60) days but this deadline may be extended for another thirty (30) days upon written notice to you. If I deny your requested amendment I will provide you with written notice of my decision and the basis for my decision. You will then have the right to submit a written statement disagreeing with my decision which will be maintained with your PHI. If you do not wish to submit a statement of disagreement you may request that I provide your request for amendment and my denial with any future disclosures of your PHI.
6. Upon request to receive an accounting of disclosures of your PHI made within the past 6 years of your request for an accounting. Disclosures that are exempted from the accounting requirement include the following:
   - Disclosures necessary to carry out treatment, payment and health care operations.

- Disclosures made to you upon request.
- Disclosures made pursuant to your authorization.
- Disclosures made for national security or intelligence purposes.
- Permitted disclosures to correctional institutions or law enforcement officials.
- Disclosures that are part of a limited data set used for research, public health or health care operations.

I am required to act on your request for an accounting within sixty (60) days but this deadline may be extended for another thirty (30) days upon written notice to you of the reason for the delay and the date by which I will provide the accounting. You are entitled to one (1) accounting in any twelve (12) month period free of charge. For any subsequent request in a twelve (12) month period you will be charged $_______ for each page copied and you will be expected to pay for the copies at the time you pick them up.

7. To receive a paper copy of this privacy notice even if you agreed to receive a copy electronically.
8. To pay out-of-pocket for a service and the right to require that I not submit PHI to your health plan.
9. To be notified of a breach of your unsecured PHI.
10. If your records are electronically maintained, the right to receive a copy of your PHI in an electronic format and to direct in writing that a third party receive a copy of your PHI in an electronic format.
11. The right to complain to me and to the Secretary of the U.S. Department of Health and Human Services (HHS) if you believe your privacy rights have been violated. You may submit your complaint to me in writing setting out the alleged violation. I am prohibited by law from retaliating against you in any way for filing a complaint with me or HHS.

Uses and Disclosures

Your written authorization is required before I can use or disclose my psychotherapy notes which are defined as my notes documenting or analyzing the contents of our conversations during our counseling sessions and that are separated from the rest of your clinical file. Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.

It is my policy to protect the confidentiality of your PHI to the best of my ability and to the extent permitted by law. There are times however, when use or disclosure of your PHI including, psychotherapy notes, is permitted or mandated by law even without your authorization.

Situations where I am not required to obtain your consent or authorization for use or disclosure of your PHI psychotherapy notes include the following circumstances:

•By myself or my office staff for treatment, payment or health care operations as they relate to you.

For example: Information obtained by me will be recorded in your record and used to determine the course of treatment that should work best for you. I will document in your record our work together and when appropriate I will provide a subsequent counselor or health care provider with copies of various reports that should assist him or her in treating you once we have terminated our therapeutic relationship.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

•In the event of an emergency to any treatment provider who provides emergency treatment to you.
•To defend myself in a legal action or other proceeding brought by you against me.
•When required by the Secretary of the Department of Health and Human Services in an investigation to determine my compliance with the privacy rules.
•When required by law in so far as the use or disclosure complies with and is limited to the relevant requirements of such law.

Examples:
To a public health authority or other government authority authorized by law to receive reports of child abuse or neglect.

If I reasonably believe an adult individual to be the victim of abuse, neglect or domestic violence, to a governmental authority, including a social services agency authorized by law to receive such reports to the extent the disclosure is required by or authorized by law or you agree to the disclosure and I believe that in the exercise of my professional judgment disclosure is necessary to prevent serious harm to you or other potential victims. If I make such a report I am obligated to inform you unless I believe informing the adult individual will place the individual at risk of serious injury.

In the course of any judicial or administrative proceeding in response to:

•An order of a court or administrative tribunal so long as only the PHI expressly authorized by such order is disclosed, or
•A subpoena, discovery request or other lawful process, that is not accompanied by an order of a court or administrative tribunal so long as reasonable efforts are made to give you notice that your PHI has been requested or reasonable efforts are made to secure a qualified protective order, by the person requesting the PHI.
•Child custody cases and other legal proceedings in which your mental health or condition is an issue are the kinds of suits in which you PHI may be requested.
•In addition I may use your PHI in connection with a suit to collect fees for my services.

- In compliance with a court order or court ordered warrant, or a subpoena or summons issued by a judicial officer, a grand jury subpoena or summons, a civil or an authorized investigative demand or similar process authorized by law provided that the information sought is relevant and material to a legitimate law enforcement inquiry, the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought and de-identified information could not reasonably be used.
- To a health oversight agency for oversight activities authorized by law as they may relate to me (i.e., audits; civil, criminal or administrative investigations, inspections, licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions).
- To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- To funeral directors consistent with applicable law as necessary to carry out their duties with respect to the decedent.
- To the extent authorized by and the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- If use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- To a public health authority that is authorized by law to collect or receive such information for the purposes of preventing or controlling a disease, injury or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth, death, and the conduct of public surveillance, public health investigations, and public health interventions.
- To a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if the covered entity or public health authority is authorized by law to notify such persons as necessary in the conduct of a public health intervention or investigation.
- To a public health authority or other appropriate governmental authority authorized by law to receive reports of child abuse or neglect.
- To a law enforcement official if I believe in good faith that the PHI constitutes evidence of criminal conduct that occurs on my premises.
- Using my best judgment, to a family member, other relative or close personal friend or any other person you identify, I may disclose PHI that is relevant to that person's involvement in your care or payment related to your care.
- To authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act and implementing authority.
- To Business Associates under a written agreement requiring Business Associates to protect the information. Business Associates are entities that assist with or conduct activities on my behalf including individuals or organizations that provide legal, accounting, administrative, and similar functions.
- To family members and others involved in your care prior to your death, unless doing so would be inconsistent with any prior expressed preferences you made known to me, but limited to PHI relevant to the family member or other person's involvement in your care or payment.

I may contact you with appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

If you have any questions and would like additional information you should bring this to my attention at the first opportunity. I am the designated Privacy Officer for my practice and will be glad to respond to your questions or request for information.

Client Consent Form

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

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

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

____

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

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
I have been provided and have received Rachael Wright's MA, LPC, RPT Notice of Privacy Practices dated January 1, 2015.

Signature of Client or Legal Representative:

____ ________________
(Full Name) *Date*

Signature of Client or Legal Representative:

____ ________________
(Full Name) *Date*

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

____

____

____

Witnessed: ____ ____________
Crossroads Child & Family Counseling, PLLC *Date*