**BHC-Behavioral Health Consultants, Inc.**
9525 Katy Freeway #312 **|** Houston, Texas 77024
Phone (713) 463-9449 | Fax (713) 463-7181

# CONFIDENTIAL INFORMATION SHEET

This information is to help us better understand you and your situation. Please fill it out as completely as you can.
All information will be held in strict confidence.

**DATE:**_____ **THERAPIST:**_____

## CLIENT INFORMATION:

Name: _____ Date of Birth: ____ /____/____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Mobile: _____ E-mail: _____

Preferred Method of communication: ☐Home Phone ☐Mobile ☐Email Gender: ☐Male ☐Female

Marital Status: _____ Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐I decline to specify

Race: ☐American Indian ☐Asian ☐Black/African American ☐Pacific Islander ☐White ☐I decline to specify

Preferred language: _____ Referred by: _____

Smoking Status: ☐Never Smoker ☐Former Smoker ☐Light Smoker ☐Heavy Smoker

## INSURANCE INFORMATION *(skip if self pay)*:

Primary Insurance: _____ Phone: _____

Employer: _____ Policy # _____ Group # _____

Subscriber: _____ SSN: ____-___-____ Subscriber's DOB:____/___/____

Secondary Insurance: _____ Phone: _____

Employer: _____ Policy # _____ Group # _____

Subscriber: _____ SSN: ____-___-____ Subscriber's DOB:____/___/____

## NEXT OF KIN / RESPONSIBLE PARTY:

Name: _____ E-mail: _____

Relationship to patient: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

1. **I, the undersigned, accept financial responsibility for payment of all fees at the time of visit, unless other arrangements have been made with the Accounting Department.**
2. **AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize the release of any information regarding my condition or treatment to insurance company.**
3. **AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.**

SIGNED:_____ DATE:_____

## PRIMARY DOCTOR INFORMATION AND CLIENT HISTORY:

Name: _____ May we contact him/her? ☐Yes ☐No
Phone: _____ Fax: _____

Why did you decide to come or why were you referred for counseling?

Have you sought counseling in the past? ☐Yes ☐No
If you answered yes, please provide details here:

Have you been treated in an inpatient facility or hospital for any mental disorder or substance abuse issues? ☐Yes ☐No
If you answered yes, please provide details here:

Are you currently taking any medication? ☐Yes ☐No
If you answered yes, please list current medications and medications tried in the past 12 months here:

Please check all concerns that apply to you:

**Relationship Problems:**
☐Friendship problems
☐Verbal conflicts
☐Trust issues
☐Sexual problems
☐Marital conflict
☐Marital distances
☐Suspicious about other People

**Eating Problems:**
☐Excessive dieting
☐Low body weight
☐Overeating
☐Vomiting after eating
☐Using laxatives
☐Oversensitive about eating

**Employment Problems:**
☐Employment termination
☐Long-term unemployment
☐Difficult boss
☐Co-worker difficulties
☐Overwhelmed with too many duties
☐Working too many hours

**Lifestyle Problems:**
☐Gambling
☐Goals not being met
☐Financial troubles
☐Debt
☐Decision-making

**Sleep Disturbance:**
☐Insomnia
☐Sleeping too much
☐Nightmares
☐Snoring
☐Acting out dreams

**Mental Disorder:**
☐Anxiety/Panic
☐Bipolar disorder
☐Depression
☐Psychosis
☐Other:_____

**Other Problems:**
☐Procrastination
☐PMS
☐Menopause
☐Menstrual problems
☐Physical problems
☐Impulsivity

☐Unable to relax
☐Shyness
☐Thinking/confusion
☐Low motivation
☐Financial trouble
☐Guilt

☐Self harm (cutting/scratching)
☐Hair pulling
☐Parenting
☐Mixed feelings
☐Indecision
☐Substance abuse

Please provide other pertinent information here that will help me better understand your situation so that I can come up with a more suitable treatment plan for you:

**I certify the information provided is correct and I authorize services to be provided to the above named patient.**

_____ _____
**Patient /Legal Guardian Signature** **Date**

## GENERAL INFORMATION AND PROCEDURES (Office Copy)

**This form provides information about our counseling relationship, procedures involved, and your authorized consent to treatment.**

**Length of Session:** Sessions are scheduled for 45- 50 minutes. This convention was established by insurance companies. Greater flexibility is possible and desirable, but may not be covered.

**Cancellations:** Your session time is reserved for you and is taken seriously. **Except for emergencies, cancellations must be made 24 hours in advance to avoid being charged. You will be charged $60.00 for no shows and late cancellations.** A 24 hour answering service, available seven days a week, is provided for your convenience at (713) 463- 9449.

**Fee Structure: The client is financially responsible for payment of fees, which will be collected at the time of service.** The client will also be responsible for any portion of fees not reimbursed or covered by health insurance. Additional cost may be incurred for use of assessment instruments. In the event of an accrued balance, the client and therapist can negotiate a payment schedule.

**Confidentiality:** Information shared in session is held in strictest confidence according to federal law (Regulation 42 CFT Part 2). Exceptions include: legal obligations (such as child abuse, elder abuse, testimony requires by a judge, personal danger to self or an identifiable victim); information provided to parents if the client is a minor; and consultation with supervising professionals. Advice may be elicited from professional peers in regard to your case, without revealing identity. Release of information to another professional may be done only with your written consent.

**Client Privacy:** Recent laws have been enacted for client privacy. It is important to know that emails and mobile phone conversations are not secure or guaranteed of privacy because they can be potentially intercepted. Therefore, by signing this document you understand that if we have correspondence by email or mobile phone, there is a potential for confidentiality to be compromised.

**Counseling Approach:** To get the most out of counseling or therapy, it is important to assume responsibility for your experience. Therapists can only help you based on the information you provide. If you are like most people, you probably have some sensitive issues you are not comfortable discussing with others. Those are usually the things you most need to talk about with your therapist. Depending on the circumstances, you may be asked to include some family members in your treatment. Regular, consistent participation in treatment sessions, as well as any "homework" assignments will help facilitate the process, but no therapist can ethically guarantee achievement of your goals. Please feel free to ask questions about the process and let your therapist know if you are not satisfied with how it is progressing. Because of the nature of the therapeutic process, you may experience periods of emotional discomfort on the way to your goals. No single therapist is the best one for every client. If you do not feel your therapist is the right fit for you, we will be happy to help you with another referral in this or another office. You are free to discontinue treatment at any time.

**As a client, I have read, understood and agree to the terms and conditions of the information presented in this form as I enter into the therapeutic process.**

_____ _____

Client's Signature Date

## CLIENT RECEIPT OF PRIVACY NOTICE
## (Office Copy)

**YOUR RIGHTS**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we shar
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

**YOUR CHOICES**

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

**OUR USES AND DISCLOSURES**

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

**By signing below, I acknowledge receiving a copy of the "Privacy Notice" of BHC-Behavioral Health Consultants, Inc. describing my right to privacy of my protected health information (PHI) under the Federal HIPAA Privacy Law, as follows:**

- **How my PHI may be used and disclosed,**
- **My privacy rights regarding my PHI,**
- **The medical practice's obligations concerning the use and disclosure of my PHI.**

Client Name/Guardian _____

Signature: _____

Date _____

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OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this notice but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |

# BHC's No Show Pre-Authorized Charge Form

I authorize BHC-Behavioral Health Consultants, Inc. to keep my signature on file and to charge my Credit Card listed below for:

☐ The one time amount of $ **60.00 in the event that I fail to cancel my scheduled appointment and failed to provide 24 hours notice.**

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

Customer Name:_____

Cardholder Name:_____

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Account Number:_____

Expiration Date:_____ Card Verification Number: _____

Cardholder Signature: X_____ Date: _____

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**USE OF PRE-AUTHORIZED CHARGE FORMS**

This form is a pre-authorization to charge credit card payments to your customers. You must still complete the actual credit card charges, including getting an authorization for each transaction.

The information on this form is to be used to fill out your charge slips, as is authorized by the cardholder for payment of future or ongoing visits.

1. The name of the service provider-your practice or business (as it appears on your card imprinter) must be filled in the top line.
2. The cardholder must choose one of the three payment schedules indicated by each of the three boxes:
    i) Charges not paid by insurance, not to exceed a designated amount, for either the current visit, or for all visits within a year.
    ii) Recurring charges of a specific amount, to be charged on a scheduled basis between two designated dates.
    iii) A total fee, of a designated amount to be charged to the customer's card one time.
3. Personal information must be completed by the provider, stating the customer's name, cardholder's name, card type, account number and expiration date. Please be careful to note that the cardholder's card expiration date does not extend beyond the "ending date" for any recurring charges.
4. The cardholder must sign and date the form at the bottom.
5. The cardholder receives the top copy, and the bottom two copies are retained by the service provider. (If there is any discrepancy regarding the charges, the provider has the second copy to supply to the cardholder's bank.)
6. The form is valid for use for one year, or until the cardholder cancels authorization through written notice to the service provider.

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_____ _____

Client's Signature Date

# NOTICE OF PRIVACY PRACTICES (Client Copy)

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

**YOUR RIGHTS**

**Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

**YOUR CHOICES**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

**OUR USES AND DISCLOSURES**

***How do we typically use or share your health information?***

We typically use or share your health information in the following ways.

**Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?**

**We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:** www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

**For more information see:** www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

*Changes to the Terms of this Notice*

***We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office***