GR&E Mind Evolution All Purpose Center
Patient Information

Patient's Name: _____ DOB: ____/____/____ Age: _____

Address: _____ City: _____ State: _____ Zip code: _____

Home phone: _____ **Cell**: _____ Work phone: _____

Email: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Minor

Employment Status: ___ Employed ___ Unemployed ___ Retired ___ Disabled ___ Student

FOR MINORS ONLY

Father's Name: _____ DOB: ___/___/___

Address: _____ City: _____ State: _____ Zip code: _____

Home phone: _____ Cell: _____ Work phone: _____ Occupation: _____

Mother's Name: _____ DOB: ___/___/___

Address: _____ City: _____ State: _____ Zip code: _____

Home phone: _____ Cell: _____ Work phone: _____ Occupation: _____

Are Parents legally married? ____ Yes ____ No

Are parents in the process of separation or divorce? ____ Yes ____ No

If parents are divorced, please indicate the name of the legal custody parent. _____

Please provide a copy of the divorce creed indicating custody rights.

***If parents have joint custody, both parents may be required to consent to treatment.

Treatment and Legal Information

Has the patient been in psychological/counseling/psychiatric treatment before? ____ Yes ____ No

If yes, please provide the name of the professional _____

Are you currently involved in a lawsuit or any legal matters? ____Yes ____ No

If yes, the attorney's name: _____

Please describe in your own words your concern for which you are seeking psychological help.

How long has the current issue/issues existed? _____

How frequently does it occur? ____ Rarely ____ Occasionally ____ Weekly ____ Daily ____ Most of the time ____ Continuously

Who can we thank for referring you to our office? _____

Assessment and Treatment Contract

Please read this document carefully and provide your initials and signature. If you have any questions, we will discuss them with you individually.

I am voluntarily consenting to allow the clinician to provide counseling services to my **dependent**, _____, or **myself**.

Your initials _____

I will be informed about the nature of the psychological assessment and/or treatment services that will be recommended. I will have the opportunity to discuss concerns. I will help in developing a treatment plan, if necessary. I may stop my assessment or treatment services at any time and have an explanation provided regarding the possible consequences of my decision. Successful termination of services is determined when the clinician agrees that the treatment goals are substantially completed.

Your initials _____

I understand that there are fees for professional services provided and that these fees have been discussed with me, I, OR MY LEGAL. GUARDIAN, ACCEPTS RESPONSIBILITY FOR THE CHARGES INCURRED. Payment is due at time of services unless other arrangements have been made.

Your initials _____

I understand that there will be a **$150.00** an hour fee if subpoenaed to appear in court.

Your initials _____

I authorize the clinician, or official representative, to communicate with my insurance company about my coverage for my dependent or myself. I authorize the release of billing information to my insurance company, Medicare, or Medicaid concerning provided services and to forward statements of charges to my home (or an alternative address if desired).

Your initials _____

THE FEE FOR MISSED APPOINTMENTS WITH LESS THAN TWENTY-FOUR HOURS' NOTICE IS $25.00. INSURANCE WILL NOT PAY FOR THIS FEE. YOU WILL BE RESPONSIBLE FOR MISSED APPOINTMENT CHARGE.

Your Initials _____

FEES FOR SERVICES

Initial Interview……	$150.00
Individual Psychotherapy, 60 minutes……	$125.00
Individual Psychotherapy, 45-50minutes……	$90.00
Individual Psychotherapy, 20-30 minutes……..	$80.00
Family Psychotherapy, 45-60 minutes…….	$125.00

I understand that I have certain rights, including the following: All civil rights guaranteed by Texas and United States Law. The right to be treated with dignity and respect without abuse or neglect. The right to an investigation of a complaint. Every reasonable effort will be made to resolve disputes. The Texas State Board of Professional Counselors 1-800-942-5540 protects the public from unethical professional behavior or behavior violating the rules of practice for Licensed Professional Counselors. The right to privacy is protected by law. Generally, all communication between the patient and a psychologist is confidential. However, I am aware of the limits to confidentiality in which information may be disclosed under the following conditions:

a. Circumstances where either others or myself are at imminent risk for serious injury (suicide) or death (homicidal)
b. Suspected abuse (including physical, mental, or sexual abuse) of a minor/disabled person/elderly;
c. Court order, or referral for criminal court evaluations.

State law mandates mental health professionals to report these situations to the appropriate persons or agencies. The right to permit information to be released with a **signed authorization** indicating what information will be released, for what reasons, and to what party.

Your initials _____

I am a Licensed Professional Counselor who works independently of any other counselors, or health care professionals. I may share business with other counselors or individuals. However, the practice is independent, not a part of a group practice, and I have sole responsibility.

____ Gina Ramirez 75353 ____ Rigoberto Longoria 82897 ____ Ana Tamez 82649
____ Amy Gonzalez 73050 ____Vanessa Diaz 77699 ____ Mark Garza 78021

Your initials _____

I have read (and had the opportunity to discuss) the above statements, which I have initialed.

X_____

SERVICE AGREEMENT FOR COLLATERALS
**********To be filled by the parent and/or family member of the client**********

Introduction

I want to thank you for the accepting invitation to assist in _____ (Client's name)

evaluation and/or treatment. Your participation is important and is sometimes essential to the success of the treatment. This document is to inform you about the risks, rights, and responsibilities of your participation as a collateral participant.

WHO IS THE COLLATERAL?
A collateral is usually a spouse, family member, or friend, who participates in therapy to assist the identified patient and provide information. The collateral is not considered to be a patient and is not the subject of the treatment. Counselors have certain legal and ethical responsibilities to the patients, and the privacy of the relationship is given legal protection. My primary responsibility is to my patient and I must place their interests first. You also have less privacy protection.

The Role of Collaterals in Therapy
The role of collateral will vary greatly. For example, a collateral might attend only one session, either alone or with the patient, to provide information to the therapist and never attend another session. In another case a collateral might attend all of the patient's therapy sessions and his/her relationship with the patient may be a focus of the treatment. We will discuss your specific role in the treatment at our first meeting and other appropriate times.

Benefits and Risks
Psychotherapy often engenders intense emotional experiences, and your participation may engender strong anxiety or emotional distress. It may also expose or create tension in your relationship with the patient. While your participation can result in a better understanding of the patient or an improved relationship, or may even help in your own growth and development, there is no guarantee that this will be the case. Psychotherapy is a positive experience for many, but it is not helpful to all people.

Medical Records
No record or char will be maintained on you in your role as collateral. Notes about you may be entered into the identified patient's chart. The patient has a right to access the chart and the material contained therein. It is sometimes possible to maintain the privacy of our communications. If that is your wish, we should discuss it before any information is communicated. You have no right to access that chart without the written consent of the identified patient. You will not carry a diagnosis, and you have no individualized treatment plan.

Fees
As collateral, you are not responsible for paying for my professional services unless you are financially responsible for the patient.

Confidentiality
The confidentiality of information in the patient's chart, including the information that you provide me, is protected by both federal and state law. It can only be released if the identified patient specifically authorized me to do so. There are some exceptions to this general rule:

- If I suspect you are abusing or neglecting a child or a vulnerable adult, I am required to file a report with the appropriate agency.
- If I believe that you are a danger to yourself (suicidal) I will take action to protect your life even if I must reveal your identity to do so.
- If you threaten serious bodily harm to another, I will take necessary actions to protect that person even if I must reveal your identity to do so.
- If you, or the patient, is involved in a lawsuit, and a court requires that I submit information or testify, I must comply.
- If insurance is used to pay for the treatment, the client's insurance company may require me to submit information about the treatment for claims processing purposes or for utilization review.
- You are expected to maintain the confidentiality of the identified patient (your spouse, friend, or child) in your role as collateral.

Do collaterals ever become formal patients?
Collaterals may discuss their own problems in therapy, especially problems that interact with issues of the identified patient. The therapist may recommend formal therapy for collateral. These are some examples of when this might occur.

- It becomes evident that collateral is in need of mental health services. In this circumstance, the collateral needs to have a therapist/clinician, diagnosis, and chart records kept.
- Parents, being seen as collaterals as their child is being treated, need couples therapy to improve their relationship so they can function effectively as parents.

Most often, but not always, your therapist/ clinician will refer you to another therapist/clinician for treatment in these situations. There are two reasons the referral may be necessary:

- Seeing two members of the same family or close friends may result in a dual role, potentially clouding the therapist's/therapist/clinician's judgment. Making a referral helps prevent this from happening.
- The therapist/ clinician must keep a focus on the original primary task of treatment for the identified patient. For example, if the therapist/ clinician started treating a child's behavioral problem, then takes on couples' therapy with mom and dad to address their relationship problems, the original focus of therapy with the child may be lost. A referral helps the therapist/ clinician to stay focused.

Release of Information
The identified patient is not required to sign an authorization to release information (Authorization Form) to the collateral when the collateral participates in therapy. The presence of the collateral with the consent of the patient is adequate; however, it is my practice to require such authorization. This provides some assurance that full consent has been given to the therapist/ clinician for the patient's confidential information to be discussed with the collateral in therapy. The Authorization Form is also helpful to the therapist/ clinician on those occasions when receiving a telephone call from collateral or when the therapist/clinician calls without an Authorization Form.

Parents as Collaterals
Therapists/ clinicians specializing in the treatment of children have long recognized the need to treat children in the context of their families. Participation of parents, siblings, and sometimes extended family members, is common and often recommended. Parents in particular have more rights and responsibilities in their role as collateral than in other treatment situations where the identified patient is not a minor.

- In treatment involving children and their parents, access to information is an important and sometimes contentious topic. Particularly for older children, trust and privacy are crucial to treatment success. But parents also need to know certain information about the treatment. For this reason, we need to discuss and agree on what information will be shared and what information will remain private. *I generally require a written contract signed by both you and your child/children concerning access to a child's record and once that contract is made, I will treat it as legally binding, although it sometimes may be overridden by a judge.* In general, I believe that parents should be informed about the goals of treatment and how the treatment is going, and whether the child comes to his/her appointments. at the end of treatment, I prepare a summary for the parents. In addition, I will always inform you if I think that your child is in danger or if he/she is endangering others. One of our first tasks is to discuss and agree on our shared definition of dangerousness so we are all clear about what will be disclosed.
- If you are participating in therapy with your child, you should expect the therapist/clinician to request that you examine your own attitudes and behaviors to determine if you can make positive changes that will be of benefit to your child.

Summary
If you have questions about therapy, my procedures, or your role in this process, please discuss them with me. Remember that the best way to assure quality and ethical treatment is to keep communication open and direct with your therapist/clinician. By signing below, you indicate that you have read and understood this document.

X_____

Privacy Notice

I, _____, have read and understand the Privacy and Confidentiality Statement made available to me by

GR&E Mind Evolution All Purpose Center. I understand my rights as a client/or guardian and agree to any and all uses and disclosures of information under the guidelines given to GR&E Mind Evolution All Purpose Center by the Health Insurance Portability and Accountability Act (HIPAA).

X_____ **Date** _____