Christian Counseling

3021 Gateway Dr. Suite 290 Irving, Texas 75063-2671 (972) 257-0449

PERSONAL DATA INVENTORY FOR MINORS

The information inside the boxes is especially important for our records and helps us serve the community better. However, Please Feel Free to Answer Only Those Questions On the Entire Questionnaire That You are Comfortable Answering

IDENTIFICATION DATA

Date: ________________________

Name of Client____ Home Phone________________________

Address ______________________________ City _____________________ Zip ______________

Primary Caregiver ____ Home Phone________________________

Address (if different from above)______________________________ City __________________ Zip __________

Cell Phone ______________________ Pager ________________________ Work Phone _________________

Please indicate where we may leave a voice message: Home ____ Work ____ Cell ____ Pager _____

Parent's email for notification of upcoming seminars- ____

Length of time at above address____________________________________

Client's Sex ________ Birth date ______________ Age _________ Place of birth__________________________

School:____________________________ Grade_______ Social Security #___________________________

HEALTH INFORMATION

Rate child's health (check): Very Good _____ Good _____ Avg. _____ Declining _____

Child's approximate weight ______ lbs. Weight changes recently: Lost _______ Gained ________

List all important present or past illnesses or injuries or handicaps: ____________________________________
____

Last physical exam date: ___________ Report:__________ Medications ________________________________

Child's physician:_________________________________ Phone Number: ______________________________

Has child ever had a severe emotional upset? Yes ___ No ___

Explain____

Has the child ever been the victim of a crime? Yes ___ No ___

If Yes, have you filed with Texas Crime Victims Compensation? Yes ___ No ___

Are you willing to sign a release of information form so that your child's counselor may write for social, psychiatric, or medical reports? Yes ___ No Explain ____

RELIGIOUS BACKGROUND

Denominational preference(current):_________________________Church Member: Y N

Church attendance per month (circle: 0 1 2 3 4 5 6 7 8+)

Church child currently attends:____

PERSONALITY INFORMATION

Has the child had any contact with the school counselor? Yes___ No ___

Has he or she ever had any psychotherapy or counseling before? Yes ___ No ___ If yes, list counselor or therapist and dates: ____

What was the outcome?____

Circle any of the following words which best describes the minor now: active ambitious self-confident persistent nervous hardworking impatient impulsive moody often-blue excitable imaginative calm serious easy-going shy good-natured introvert extrovert likable leader quiet hard-boiled submissive lonely self-conscious sensitive. Other:

____

FAMILY INFORMATION

Father's name______________________________ Age_______ Education____________________

Mother's name______________________________ Age________ Education___________________

Father's Occupation____________________________ Work Phone ( )_________________

Mother's Occupation____________________________ Work Phone ( )_________________

Are the mutual parents married? ___________ separated? ____________ divorced? _____________

List all children in the family

Name	Age	School grade
______________________________	_____	__________
______________________________	_____	__________
______________________________	_____	__________

Who is responsible for payment of services? _________________________ Phone Number _______________

Address ____City ___________________ Zip ________________

In case of emergency, whom shall we contact (other than parents)?

____

Name, Address, Phone

I solemnly swear that all of the above information is true to the best of my knowledge.

____

Signature of Parent or Guardian

Rapha Christian Counseling
972-257-0449 Toll Free 1-877-257-0449
3021 Gateway Dr., Suite 290, Irving, Texas 75063-2671
Fax: 972-258-0449 E-mail: info@rapha.info

INSURANCE CONSENT FORM

The Following is REQUIRED if your therapist is Filing Health Insurance Claims on Your Behalf

I authorize use of this form on all my insurance submissions and I permit a copy of this authorization to be used in place of the original. I authorize my therapist to act as my agent in helping me obtain payment from my insurance companies. I authorize release of information to all my insurance companies. I authorize payment for services to be made directly to my therapist.
_______ Initial

I understand that **I am responsible for my bill, not my insurance company.** I am aware that in the event insurance declines payment that I am still responsible for my bill. I authorize payment direct to my therapist. I authorize my therapist to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
_______ Initial

I understand I am responsible for all copays and yearly deductibles charged by the insurance company. I understand it is my responsibility to inform my therapist of any changes to my insurance while in therapy.
_______ Initial

EMPLOYER INFORMATION:
(We do not release information to employers, only to insurance companies. This information is needed for processing insurance claims only.)

____
Employer

(_____)________________________________ ____________________________________
Phone Number Member ID#

IMPORTANT NOTICE: If a diagnosis is rendered, it will become part of your permanent medical records. Please be aware that it is the prerogative of the insurance companies to pay for a claim or not. Should they decline, payment becomes the client's responsibility.

It is against the Texas Insurance Code to waive deductibles and copayment charges. This is considered a "kickback" and is treated as fraud by the State Attorney's office. If your therapist is filing insurance for you, you will be expected to pay your portion of the standard charges for service as required by your policy.

Name of Policyholder: ____
Please print

Signature of Policyholder: __________________________________ **Date:** ______________________

Signature of Claimant, if other than Policyholder: ____

See the Notice of Privacy Practices for detailed information regarding the disclosure of PHI (Protected Health Information). Briefly, your PHI, name, address, social security number, etc., may be used by your therapist for purposes of treatment, payment and healthcare operations during our normal business operations.

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PATIENT FINANCIAL CONSENT STATEMENT

All fees for counseling are due after each session unless other arrangements have been made beforehand. RCC accepts payment by exact cash/check/VISA/MC. Future appointments may be discontinued until your balance is paid or other payment arrangements have been made with your counselor. If you have any questions concerning your account, please call your counselor at 972-257-0449.

If a check is returned to us, a processing fee of $35.00 will be assessed to your account. Additionally, you will need to make a cash or money order payment for the amount of the returned check and the $35 processing fee. Your counselor may require cash payment for future appointments after he/she receives a returned check(s). Your counselor will establish the fee for late cancellations or no shows.

Counselors have their own standard fee for sessions. However, you may request a professional discount from your counselor. Fees are subject to change at anytime during the course of your therapy.

I have read, understand and agree to the payment information as stated above.

____
Client's Signature

PROFESSIONAL DISCLOSURE AND CLIENTS RIGHTS STATEMENT

Regarding the nature of Counseling: As you talk about your thoughts, feelings, and experiences, we will work together as partners to gain the understanding and insight necessary for change to come about. Any goals for counseling and/or decisions you make to facilitate change are ultimately up to you. Some clients need only a few counseling sessions to achieve their goals; others may require months or even years of counseling. As a client, you may end our counseling relationship at any time without any additional moral, legal, or financial obligation, though I do ask that you participate in a termination session. At any time, either you or I may initiate discussion of possible positive or negative effects of continuing or not continuing counseling, and/or using or not using certain techniques. You have the right to ask any questions about the procedures used during therapy. If you wish, I shall explain all therapeutic procedures and their rationales to you.

Regarding Counseling Sessions and the Counseling Relationship: Sessions are usually held weekly for about 50 minutes. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to counseling sessions you arrange with me except in case of emergency when you may contact RCC by phone. Due to ethical guidelines, I ask that you do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling sessions. You will be best served if our sessions concentrate exclusively on your concerns. My services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results for you.

You will be informed of and have the right to prevent any electronic recording of any part of the therapy sessions. Tape recording of therapy sessions could be used for the purpose of review by you or myself in order to maximize the benefit to you of our time together. You also have the right to withdraw your permission to record at any time.

There are certain situations in which, as a therapist, I am required by ethical standards to reveal information obtained during therapy to other persons or agencies - even if you do not give permission. Those situations are outlined in the document “Notice of Privacy Practices.” If you have any questions about those situations, please review the document available from our office staff.

You have the right to decide not to receive psychotherapy from me; if you wish, I shall provide you with the names of other qualified therapists. A verbal exploration of alternatives to counseling will also be made available upon request. If at any time you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns you may report your complaints to my supervisor or the Executive Director of RCC. You have the right to address any complaints against licensed professional counselors to the Texas State Board of Examiners of Professional Counselors, 1100 West 49th Street, Austin, Texas 78756, 1-800-942-5540 or complaints against social workers to Texas State Board of Social Workers Examiners (same address), 1-800-232-3162.

If counseling is being provided at a satellite office (church, denominational office, ministry, business etc.) please be advised that Rapha Christian Counseling is a separate entitiy from that church/ministry/business. This church/ministry/business is only providing space for counseling and not otherwise connected in any way.

By signing below you are stating that you have read and understood this policy statement. In addition you consent to participate in evaluation and/or treatment. You have had your questions answered concerning this document to your satisfaction.

Client: ____ Therapist: _____________________________ Date: __________

NOTICE OF PRIVACY PRACTICES

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

We are required by The Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by the practice, and of your individual rights and the practice's legal duties with respect to confidential information.

Ways in Which We May Use and Disclose your Protected Health Information:

We may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment and healthcare operations.

- **Treatment** means providing, coordinating, or managing mental health care and related services. *For example* – use or disclosure by the health care provider in training programs in which "students, trainees, or practitioners in mental health" learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.

- **Payment** means activities such as obtaining payment for the mental health care services we provide for you either from your insurance or another third party payer. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, and procedures performed.

- **Health care operations** include the business aspects of running our practice. *For example* – to evaluate our treatment and services, or to evaluate our staff's performance while caring for you.

We may contact you to provide appointment reminders or other services that may be of interest to you. We will disclose your protected health information to any person *you identify* that is involved in your care or payment for your care. For example - a family member, relative, close friend, a pastor or pastor's representative whom you have asked us to communicate with.

We will use and disclose your protected health information *when required to by federal, state, or local law*. There are certain situations in which, as a therapist, I am required by ethical standards to reveal information obtained during therapy to other persons or agencies - even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or are ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke an authorizaion in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate you understand our operational use of your information for treatment, payment and healthcare operations as stated above.

____ __________________________

Signature of Client/Responsible Party Date

NOTICE OF PRIVACY PRACTICES CON'T

Your Health Information Rights:

Although your records are the physical property of Rapha Christian Counseling, the information belongs to you. Your have the following rights with respect to your information, which you can exercise by presenting a written request to our office manager.

You have:

- The right to request restrictions on certain uses and disclosures of your information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. For example – a request that we not identify the agency when we contact you. (i.e.- "This is Rapha Christian Counseling calling")
- The right to inspect and copy the information that we maintain about you. However, we ***may deny an individual access***, provided that the individual is given a right to have such denials reviewed, in the following circumstances:
  - a health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to ***endanger the life or physical safety of the individual or another person***;
  - the information makes ***reference to another person*** (unless the other person is a health care provider) and the health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
  - The request for access is made by the individual's personal representative and the health care provider has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to ***cause substantial harm to the individual or another person***.
  - If you wish to inspect or copy your information, you must submit your request in writing to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.
- The right to billing records.
- The right to revoke your consent to release information except to the extent that the agency has taken actions in reliance on the previously signed consent form.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. For example – at your regularly scheduled appointment at a church satellite office, or by e-mail or fax.
- The right to amend your information if you feel that it is incomplete or inaccurate. You must make this request in writing to your therapist stating exactly what information is incomplete or inaccurate and your reasoning to support your request. We will respond to your request with in sixty (60) days. In rare cases your request may be denied. For a complete description of Rights of Amendment, please contact our office manager.
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request.
- The right to file a complaint if you believe we have violated your medical information privacy rights. You have the right to file a written complaint to our office manager, or Executive Director , or directly to the Secretary of Health and Human Services

To file a complaint with our practice, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Todd Linder, Executive Director, Rapha Christian Counseling, 3021 Gateway Drive, Suite 290, Irving, Texas 75063-2671. You should know there will be no retaliation for your filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. If and when one is available, you may request a written copy of a revised notice from this office.