# BEAR CREEK COUNSELING CENTER
## 15430 Ridge Park Drive
## Houston, TX 77095

Phone: 281-858-5874 / Fax: 281-858-5876
www.bearcreekcounseling.com

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May we leave messages on your voicemails? YES / NO Email: ______________________________

**HOW DID YOU FIND OUT ABOUT BEAR CREEK COUNSELING CENTER?**

Internet: □ BCCC Website □ Psychology Today □ Internet Search Engine: ____________________

Professional: □ Pastor:____________________ □ Church: ____________________

□ School Counselor/Teacher: ____________________ □ Counselor/Therapist: ____________________

□ Physician ____________________ □ Other: ____________________

Advertising: □ Sign/Drive By □ Neighborhood Newsletter: ____________________

**Patient Information**

Name of Patient: ______________________________ Home Phone: ____________________

Address: ______________________________ Work Phone: ____________________

______________________________ Cell Phone: ____________________

DOB: ________ / ________ / __________ Age: __________ SEX: ____________ SS#____________________

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Employer: ______________________________

Employer's Address: ______________________________

**Family Information**

Name of Spouse or Parent: ______________________________ Home Phone: ____________________

Address: ______________________________ Work Phone: ____________________

______________________________ Cell Phone: ____________________

DOB: ________ / ________ / __________ Age: __________ SEX: ____________ SS#____________________

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Employer: ______________________________

Employer's Address: ______________________________

**Insured Information**

Policy Holder's Name: ______________________________ DOB: ______ / ______ / ______

Insurance Company: ______________________________

ID #: ______________________________ Group #: ____________________

Employer: ______________________________ SS#: ____________________

Insurance Company Phone #: ______________________________

Relationship to Patient: ______________________________

**Reason for appointment:** ______________________________

______________________________

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## General Information and Procedures

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

**Length of Session:** 45-50 minutes

**Cost of Session:** $165.00

**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. Monday appointments must be cancelled by the previous Friday. **A charge of $85 will be made for missed appointments**. A 24-hour voice-mail paging service, available 7 days a week, is provided for your convenience at 281-858-5874.

**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/plan.

**Confidentiality:** Information shared in session is held in the strictest of confidence according to federal law (regulation 42 CFT Part 2). Exceptions include: legal obligations (such as child abuse, elder abuse, testimony required 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 your identity. Release of information to another professional may be done only with your written consent.

**Counseling Approach:** The client is held responsible for his/her feelings and behavior while focusing on the "problem" rather than the symptoms. Depending on the therapy issues, various family members may be requested to attend counseling sessions. Although regular attendance will produce the maximum benefits, no therapist can ethically guarantee achievement of goals. The client is encouraged to ask questions about the process during the course of therapy, and is free to discontinue therapy at any time. Because of the nature of the counseling process, the client may experience emotional strains, and may possibly make life changes that could be distressing.

**The signature below confirms that the information has been read and discussed with the therapist, and I ______________________________ accept the policies listed above. I hereby give fully informed consent to therapist Steve Hartman M.A., LPC to enter into a psychotherapy relationship with me.**

| | |
|---|---|
| ______________________________ | ______________________ |
| **Patient Name (PLEASE PRINT)** | **Date of Birth** |
| ______________________________ | ______________________ |
| **Patient Signature** | **Date** |
| ______________________________ | ______________________ |
| **Parent Signature, if Minor** | **Date** |

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**Assignment of Benefits Authorization**

I hereby authorize payment to Bear Creek Counseling Center for the medical benefits otherwise payable to me, but not to exceed therapist's charge. I understand that I am financially responsible for charges not covered by this authorization.

I hereby authorize Bear Creek Counseling Center to release to my insurance company any clinical information that is required to assist with the filing of my insurance claim. This may include any clinical options, diagnosis, treatment plan, and history information.

I further agree not to hold Steve Hartman, M.A., LPC or their associates liable for the disclosure of such clinical information, as it is at my request that such be provided. I also understand that my insurance company will be requesting detailed and specific historical information, and hereby authorize such release of such.

**Benefit and authorization is a determination based upon medical necessity and is not a guarantee of claim payment. Payment determination will be made at the time a claim is received and will be based on eligibility, plan limits, plan exclusions, and overall plan language.**

**All insurance benefits verifications are subject to final payment from your insurance company and are not the responsibility of this office.**

| | |
|---|---|
| ______________________________ | ____________________ |
| **Patient Name (PLEASE PRINT)** | **Date of Birth** |
| ______________________________ | ____________________ |
| **Patient Signature** | **Date** |
| ______________________________ | ____________________ |
| **Parent Signature, if Minor** | **Date** |

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I have provided Bear Creek Counseling Center with my credit card number and authorize them to keep my signature on file, and to charge my credit card account for all insurance payments paid directly to me that were due to this office; for all missed appointments and for all balances. I understand that this form is valid unless I cancel the authorization through written notice to this clinic.

**We DO NOT accept American Express or Discover.**

Patient's Name: ______________________________________________________________

Card Type: _____ Visa
_____ MasterCard

Charge Card Number: ______________________________________________________________

Expiration Date: ______________

Card Holders Name: ______________________________________________________________

Card Holders Signature: X ______________________________________________________________

Date: ______________________________________________________________

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**Please List Current Medications for Medical and Psychiatric Conditions:**

| Name of Medication | Current Dosage | Start Date | Side Effects |
|---|---|---|---|
| ______________ | ______________ | ______________ | Yes / No |
| ______________ | ______________ | ______________ | Yes / No |
| ______________ | ______________ | ______________ | Yes / No |
| ______________ | ______________ | ______________ | Yes / No |
| ______________ | ______________ | ______________ | Yes / No |
| ______________ | ______________ | ______________ | Yes / No |
| ______________ | ______________ | ______________ | Yes / No |
| ______________ | ______________ | ______________ | Yes / No |
| ______________ | ______________ | ______________ | Yes / No |

Who is financially responsible for this bill? ____________________________________________

I will be paying today by: [_____] Cash [_____] Check [_____] Credit Card

Texas Driver's License #: ____________________________________________

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. If for any reason, a scheduled appointment cannot be kept, cancel at least 24 business hours **BEFORE** the appointment, or **A NO SHOW FEE OF $85.00 WILL BE MADE.** **The credit card number you gave us when you scheduled your initial appointment will guarantee this appointment and all future appointments.** I have read all information on the following page, regarding financial agreements & insurance benefits and have completed the above information. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

______________________________ ______________________

**Patient Name (PLEASE PRINT)** **Date of Birth**

______________________________ ______________________

**Patient Signature** **Date**

______________________________ ______________________

**Parent Signature, if Minor** **Date**

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**Receipt of Notice of Privacy Practices**

Patient Name (PRINT): ______________________________

Patient Date of Birth: ______________________________

Given to Patient on: ______________________________

Version/Effective Date: **April 14, 2003**

______________________________ ______________________________
Signature of Patient or Personal Representative  Date

______________________________
Relationship of Personal Representative to the Patient

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Modified Version Given: ______________ Version Effective Date: ______________

______________________________ ______________________________
Signature of Patient or Personal Representative  Date

______________________________
Relationship of Personal Representative to the Patient

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# EMAIL AND TEXT MESSAGING CONSENT

## AUTHORIZATION FOR HOME/CELL TELEPHONE COMMUNICATION

I authorize Bear Creek Counseling Center and all providers who provide care, staff, and billing representatives and/or collection agents who work on their behalf, to contact me for the purposes of payment for services and/or for appointment related matters by home phone or cell phone, use of pre-recorded messages, artificial voice message, automated dialing services or other computer assisted technology.

☐ Agree ☐ Decline

## AUTHORIZATION FOR ELECTRONIC HEALTHCARE COMMUNICATIONS

I authorize Bear Creek Counseling Center to contact me for the purpose of healthcare-related messages (e.g. appointment reminders) and/or to leave pre-recorded or artificial voice messages from automated dialing services or other computer-assisted technology via:

**Email** ☐ Agree ☐ Decline

**Text** ☐ Agree ☐ Decline

**Phone** ☐ Agree ☐ Decline

____________________________
Patient/Guardian Signature

____________________________
Print Name

____________________________
Relationship to patient

____________________________
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.**

This Notice is effective as of April 14. 2003.

We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

We are required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room (IF APPLICABLE: and on our web site). You may request a copy of the revised Notice at any time. We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer also will take your complaints and can give you information about how to file a complaint. Our Privacy Officer is **Steve Hartman. M.A.. LPC** You can contact the Privacy Officer at *281/858*- 5874. **Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care operations.**

We may use information in your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if we want an opinion about your condition from a specialist, we may disclose information to the specialist to obtain that consultation.
We may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may use or disclose information from your record to allow "health care operations". These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

**YOUR RIGHTS**
You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions. You have a right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us.

You have a right to inspect the information in your record, and may obtain a copy of it. **This may be subject to certain limitations and fees.** Your request must be in writing. If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. **Your request must be in writing.**

You have the right to request an accounting of certain disclosures made by us. You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your health information).

You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints. Except as described in this Notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation.

In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization Use or disclosure of your protected health information that we are required to make without your permission. In certain circumstances, we are required by law to make a disclosure of your health information. For example, state law requires us to report suspected child abuse or neglect. Also, we must disclose information to the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information. Use or disclosure of your protected health information that we are allowed to make without your permission. There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

If you receive mental health care, including treatment for substance abuse, information related to that care may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others. We may use or disclose information from your record if we believe it is necessary to prevent or lessen a serious and imminent threat to the safety of a person or the public. We may report suspected cases of abuse, neglect, or domestic violence involving adult or disabled victims.

We may report births and deaths to public health authorities, as well as certain types of diseases, injuries, adverse drug reactions, and product defects. We may disclose information from your record to a medical examiner or coroner.

We may disclose information to funeral directors to allow them to carry out their duties upon your death.

We may disclose information from your record to facilitate organ, eye, or tissue donation and transplantation.

We may assist in health oversight activities, such as investigations of possible health care fraud. We may disclose information from your record as authorized by workers' compensation laws.

We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even if this is not ordered by a court.

We may disclose information from your record to a law enforcement official if certain criteria are met. For example, if such information would help locate or identify a missing person, we are allowed to disclose it.

If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, we may not disclose the information to law enforcement officials.

We may use or disclose information from your record for research under certain conditions. Under certain conditions, we may disclose information for specialized government purposes, such as the military, national security and intelligence, or protection of the President.

IF APPLICABLE: Your provider (or office staff) may contact you to provide appointment reminders as a courtesy. However you are responsible for remembering your appointment.

IF APPLICABLE: We may contact you with information about treatment alternatives or other health- related benefits or services that may be of interest to you. **NOTICE OF PRIVACY PRACTICES PERTAINING TO SUBSTANCE ABUSE RECORDS**

The confidentiality of protected health information related to alcohol and drug abuse is protected by federal law and regulations. Violations of the applicable federal law and regulations is a crime, and may be reported to appropriate authorities.

We may not disclose any information about you unless you authorize the disclosure in writing, except as specified below.

We may disclose information about you if a court orders the disclosure.

We may disclose information about you in a medical emergency, to permit you to receive needed treatment.

We may disclose information about you for purposes of program evaluation, audits, or research.

We may disclose information about you if you commit a crime on our premises or against any person who works for us, or if you threaten to commit such a crime.

We are required to disclose information about you if we suspect child abuse or neglect. Except as stated in this notice, you have the same rights and protections with respect to your health information as described in our general Notice of Privacy Practices.

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# Authorization to Release Information

I, ______________________________________ authorize__________________________________________ and
[Name of Patient]

_____________________________________________________________________________________________,
[Name of Person(s) or Organization(s) which disclosure is to be made to and/or received from]

to disclose or release one to the other the following information from my records:

_____ All Health Care Information
_____ Health Care Information or Opinions Relating to Any or All of the Following Treatment(s) and, or Conditions:

_____ 1) Psychiatric or Mental Health Information
_____ 2) Academic & Confidential School Information
_____ 3) Testing
_____ 4) Other ____________________________________________________________

For the purpose of treatment/management and or supervision of psychological and or medical condition(s), **I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

____________________________________________ ______________________________
Signature of Patient Date

____________________________________________ ______________________________
Signature of Parent or Legal Guardian, if Minor Date

____________________________________________ ______________________________
Signature of Witness Date