Brent Glass LPC-S, Counseling Services

6220 Gaston Avenue, Suite 403 - Dallas, Texas - 75214

New Client Information

Please complete this form for the person for whom the appointment was scheduled.

Name:_____ SS#_____ Date of Birth:_____

Address: _____

Home Phone:_____Work Phone:_____ Cell Phone:_____

Email:_____

Preferred Contact Number (mark one): ☐ **Home** ☐ **Work** ☐ **Cell** ☐ **Email**:_____

I give consent to receive communications via (mark all that apply): ☐ **phone**, ☐ **email**, ☐ **text/SMS**

Preferred Contact address:_____

I give consent to receive correspondence at the address identified above? ☐ **Yes** ☐ **No**

Occupation:_____ Company/School:_____

Others living in the home:

Name	Age	Relationship

Emergency Contact:_____ Phone:_____

Emergency Contact Relationship: _____

Please describe how you heard about our services: _____

Have you previously seen a counselor or therapist? ☐ Yes ☐ No

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Previous therapist/counselor's name and approximate dates of treatment: _____

Please describe any current medical issues: _____

_____

Please list any current medications:

Medication Name	Dosage	Prescribing Doctor	Use/Taken For

Please describe briefly your concerns for today:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you currently having thoughts of hurting yourself or someone else? ☐ Yes ☐ No

If yes, please describe: _____
_____

_____ _____ _____

Signature of person completing form | Relationship to client | Date

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Brent Glass LPC-S, Counseling Services

6220 Gaston Avenue - Suite 403 - Dallas Texas 75214 (214) 334-2746

CONSENT TO TREATMENT

I/we, _____, the undersigned, hereby grant permission for therapy to be conducted by Brent Glass, LPC. I/we understand that the therapy sessions and records are strictly confidential except where the state law requires the reporting of threats of violence, harm, or child abuse and neglect (from suspicion or evidence), and when information is subpoenaed by the courts or officers of the court.

_____ **initial/date**

The standard fee for a 45 minute therapy session is $120.00 or the rate contracted by your insurance company. Certain insurance policies may require only a co-pay and you agree to assign insurance benefits to Brent Glass, LPC. I/we accept financial responsibility for charges I/we incur during the course of treatment. I/we agree to give at least 24 hours advance notice if unable to keep an appointment. I/we understand that there is a service charge of $80.00 for missed appointments not canceled 24 hours in advance. I/we understand that failure to show for my scheduled appointment, and/or calling to cancel after the actual time of the appointment, will be documented as a no-show. I/we understand that 2 no-shows will result in chart closure.

_____ **initial/date**

I/we understand that results or outcomes from the therapy process cannot be guaranteed. I/we understand that we can question any therapeutic approach utilized at any time. If I/we decide to terminate therapy I/we will discuss termination with the therapist.

Complaints can be filed with the Texas State Board of Licensed Professional Counselors at (512)834-6658.

_____

Print Name of Client

_____ _____

Client's Signature **Date**

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Authorization for credit card payment of account balances: Credit card authorization is required for the payment of any administrative fees related to rescheduling, document requests, or other fees incurred. Please complete the following information for your first visit.

Name as appears on the card: _____

Type of card: _____

Card Number: _____

CVV Number: _____

Expiration Date:_____

Billing address for card listed above:

_____Apt #:_____

City:_____State:_____Zip: _____

I authorize the above card to be billed for any unpaid balances or charges. This authorization shall expire 180 days from the date below.

_____

Signature

_____

Date

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Notice of Privacy Practices and Client Consent for Use and Disclosure of Protected Health Information (PHI)

Privacy Practices:

I acknowledge receipt of Notice of Privacy Practices. Your counselor may change the terms of this notice at any time. Upon the client's request, the counselor will provide a revised Notice of Privacy Practices.

Uses and Disclosures of Protected Health Information:

Your PHI may be used by your therapist for the purpose of providing treatment to you. Your PHI may also be used and disclosed for billing purposes and reimbursement from your health insurance company.

Client Consent for Use and Disclosure of PHI

With my consent my therapist may call my home or designated number and leave a message or voicemail in reference to carrying out treatment options (appointment information, insurance information, reminders and returned calls). I agree my therapist may mail to my home or other designated address items that may assist in carrying out treatment options and that the items will be marked "personal and confidential".

By signing this form, I have reviewed and given consent to my therapist's use and disclosure of my PHI to carry out appropriate treatment options. I may revoke my consent in writing except to the extent that the practice has already made such disclosure. My therapist may decline to provide services to me if I choose to revoke my consent to use and disclose my PHI to carry out my treatment options.

_____
Printed Name of Client

_____
Client Signature

_____
Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES (NOTICE) DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

I. Who Presents this Notice

This Notice describes the privacy practices of _**Brent Glass M.Ed., LPC**__as your licensed professional counselor ("LPC"). This Notice applies to services furnished to you by the LPC involving the use or disclosure of your health information.

II. Privacy Obligations

LPC is required by law to maintain the privacy of your health information, referred to as "Protected Health Information" or "PHI," and to provide you with this Notice of legal duties and privacy practices with respect to your PHI. When LPC uses or discloses your PHI, LPC is required to abide by the terms of this Notice.

III. Permissible Uses and Disclosures Without Your Written Authorization

In certain situations, which are described in Section IV below, your written authorization must be obtained in order to use and/or disclose your PHI. However, LPC does not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures For Treatment, Payment and Health Care Operations. In general, your PHI may be used and disclosed to treat you, obtain payment for services provided to you and conduct "health care operations" as described below:

- Treatment. Your PHI may be used and disclosed to provide treatment and other services to you -- for example, to diagnose and treat your injury or illness. Your PHI also may be disclosed to other providers involved in your treatment.
- Payment. Your PHI may be used and disclosed to obtain payment for services provided to you -- for example, disclosures to obtain payment from Medicare, the Texas Medicaid program, your private health insurer, HMO, or other public or private third parties that arrange or pay the cost of some or all of your health care ("Your Payor") to verify that Your Payor will pay for health care.
- Health Care Operations. Your PHI may be used and disclosed for health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care delivered to you.

Your PHI also may be disclosed to your other health care providers, when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance. In addition, your PHI may be shared with business associates who perform treatment, payment and health care operations services on behalf of LPC.

C. Use or Disclosure for Additional Benefits. LPC may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

D. Disclosure to Relatives, Close Friends and Other Caregivers. Your PHI may be used or disclosed to family members, other relatives, close personal friends or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if (1) your agreement is obtained; (2) you are provided with the opportunity to object to the disclosure, and you do not object; or (3) it can be reasonably inferred that you do not object to the disclosure. Your PHI also may be disclosed in order to notify (or assist in notifying) such persons of your location or general condition.

E. Public Health Activities. Your PHI may be disclosed for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to federal or state authorities authorized by law to receive such reports; (3) to report information about products or services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may be at risk of spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work related illnesses and injuries or workplace medical surveillance.

F. Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

G. Health Oversight Activities. Your PHI may be disclosed to a state or federal health oversight agency that oversees the health care system, or another agency that is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

H. Judicial and Administrative Proceedings. Your PHI may be disclosed in the course of a judicial or administrative proceeding in response to a legal order or other lawful process, so long as the court order or process complies with applicable federal and Texas law.

I. Law Enforcement Officials. Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena, so long as the court order or subpoena complies with applicable federal and Texas law.

J. Decedents. Your PHI may be disclosed to a coroner, medical examiner or funeral director as authorized by law.

K. Health or Safety. Your PHI may be used or disclosed to prevent or lessen a serious and imminent threat to your, a person's or the public's health or safety.

L. Specialized Government Functions. Your PHI may be used or disclosed to federal officials for lawful intelligence, counter-intelligence, and other national security activities. If you are a member of the armed forces or a foreign military authority, your PHI may be used or disclosed to the appropriate military authorities under certain circumstances.

M. Workers' Compensation. Your PHI may be disclosed as authorized by, and to comply with, state law relating to workers' compensation or other similar programs.

N. Disaster Relief. Your PHI may be disclosed to the American Red Cross, or other agencies that provide similar services, in order to access any information necessary to perform its duties to provide biomedical services, disaster relief, disaster communication, or emergency leave verification services for military personnel.

O. As Required by Law. Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories.

IV. Uses and Disclosures Requiring Your Written Authorization

A. Use or Disclosure with Your Authorization. For any purpose other than the ones described above in Section III, your PHI may be used or disclosed only when you provide your written authorization on an authorization form ("Your Authorization").

B. Marketing. Your Authorization must be obtained for any use or disclosure of your PHI for marketing purposes, except if the communication: (i) is in the form of face-to-face communication made by LPC to the individual; (ii) is in the form of a promotional gift of nominal value provided by LPC to the individual; or (iii) is made to describe LPC's services (or payment for such services) that are provided by LPC.

C. Uses and Disclosures of Your Highly Confidential Information. In addition, federal and Texas law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental health and/or mental retardation services; (3) is about alcohol and drug abuse prevention, treatment, and referral; (4) is about HIV/AIDS or other sexually transmitted disease testing, diagnosis or treatment; (5) is about child abuse and neglect; or (6) is about sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization must be obtained.

D. Reidentified Information. LPC shall not reidentify or attempt to reidentify you as the subject of any PHI without obtaining your consent or authorization if required under state or federal law.

E. Use and Disclosure of Information Upon Admission to a Psychiatric Unit or Chemical Dependency Treatment Center. Information regarding your care in LPC's psychiatric unit or chemical dependency treatment center is subject to special protections under Texas and federal law. The terms of this Notice shall apply to your PHI unless otherwise described in this Section.

- Psychiatric Treatment. As stated above, LPC may use and disclose your PHI to other health care professionals and personnel under the professionals' direction for purposes of treatment and payment. On occasion, LPC may use or disclose your PHI to qualified personnel for certain health care operations, but to the extent possible, your personally identifiable information will be removed. LPC will not respond to inquiries about your treatment and will not disclose information revealing that you are a patient to unauthorized individuals, including family members, who call LPC to seek information, unless you have provided LPC with written consent. Your PHI will not be disclosed to family members or any other person seeking information about your care unless you provide written consent, or unless otherwise permissible under federal or state law.

- Alcohol and Drug Abuse Treatment. If you are a recipient of treatment for alcohol or drug abuse, your PHI related to such treatment is protected by federal confidentiality laws (42 U.S.C. 290dd-3, 290ee-3 and 42 CFR Part 2). Violations of these laws is a crime and may be reported to appropriate authorities. LPC will not disclose any PHI relating to your substance abuse treatment unless: (1) you provide written consent; (2) a court order requires disclosure of the PHI; (3) medical personnel need the information to meet a medical emergency; (4) qualified personnel use the information for the purpose of conducting scientific research, management or financial audits, or program evaluation; or (5) it is necessary to report a crime or threat of a crime or to report abuse as required by law.

V. Your Rights Regarding Your Protected Health Information

A. For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision made about access to your PHI, you may contact LPC. You may also file written complaints with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. Upon request, LPC will provide you with the procedures for filing a complaint and correct address for the Secretary. LPC will not retaliate against you, if you file a complaint with the Secretary.

B. Right to Request Additional Restrictions. You may request restrictions on the use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While all requests for additional restrictions will be carefully considered, LPC is not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from LPC.

C. Right to Receive Confidential Communications. You may request, and LPC will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

D. Right to Revoke Your Authorization. You may revoke Your Authorization, except to the extent that LPC has taken action in reliance upon it, by delivering a written revocation statement to LPC.

E. Right to Inspect and Copy Your Health Information. You may request access to, and copy, your medical record file and billing records maintained by LPC. Under limited circumstances, you may be denied access to a portion of your records. If you desire access to your records, please obtain a record request form from LPC and submit the completed form to LPC. If you request copies, you will be charged in accordance with federal and state law. You also will be charged for postage costs, if you request that the copies be mailed to you.

F. Right to Amend Your Records. You have the right to request that PHI maintained in your medical record file or billing records be amended. If you desire to amend your records, please obtain an amendment request form from LPC and submit the completed form to LPC.

G. Right to Receive An Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made during any period of time prior to the date of your request, provided such period does not exceed six years, and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, you will be charged.

H. Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

VI. Effective Date and Duration of This Notice

A. Right to Change Terms of this Notice. The terms of this Notice may be changed at any time. If this Notice is changed, the new notice terms may be made effective for all PHI that LPC maintains, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice will be posted in the waiting areas and you will be given an updated copy. You also may obtain any new notice by contacting LPC.