Griffin Therapy Center

EMPOWERMENT FOR HEALING

Intake

By filling out the following in its' entirety, you are freeing up your appointment to discuss your therapeutic needs. Please take a moment to fill in all the information below.

Child's Name _____ Date of Birth _____ Gender _____

Address _____ City _____ Zip _____

Parent Cell _____ Okay to send text reminders? _____

Parent Cell _____ Email _____

What are your primary reasons for seeking counseling for your child at this time?

_____

_____

How long have you been concerned about this problem? _____

Have you ever been to Griffin Therapy Center before? _____

About Us

Thank you for choosing Griffin Therapy Center. We're a dedicated private practice counseling agency providing out-patient mental health care. We believe successful growth and healing begins with a collaborative relationship between the client and therapist. We will work together to navigate your concerns and determine how your thoughts affect both your feelings and behavior. From this understanding you can feel empowerment to choose new direction and healing.

Counseling can hold great benefits such as: improved understanding of yourself and others, progress toward defined goals and objectives, greater moods and behavior management, improved self-esteem and self-assertion, relationship enhancement, and an improved capacity for independence. Potential risks of counseling include a lack of progress, upsetting insight, and feelings of distress.
We DO NOT provide emergency and/or crisis services. For all crises and/or emergencies, please 911 or visit your nearest emergency room. You can additionally call the Crisis Help Line at 972-233-2233 or the Teen Help Line at 972-233-8336.

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Limits of Confidentiality

The relationship between you and your therapist will be based on trust, rapport and common effort of you achieving your therapeutic goals. For this to occur, your therapist must maintain professional boundaries and follow the regulations of licensure. Your relationship is limited to a professional one, and will not include any components of a social relationship. Contact with your counselor will be limited to communication directly related to your counseling process. If you see your counselor in public, we will continue to protect your confidentiality by not acknowledging you in that setting.

In the event that your therapist becomes incapacitated or dies, your records and treatment coordination responsibilities will transfer to the agency of Griffin Therapy Center.

The law protects the relationship between a client and a psychotherapist or psychiatrist, meaning information cannot be disclosed without parent or guardian written permission. Exclusions include:

- I must break confidentiality if a client is threatening serious bodily harm to another person/s, in order to notify the police and to inform the intended victim.
- I am required by law to immediately report any suspected child or elder abuse to the appropriate authority.
- If a client intends to harm him or herself, I will make every effort to enlist their cooperation to ensure client safety. If he or she does not cooperate, I will take further measures without permission that are provided to me by law in order to ensure safety.

_____	_____	_____
Your Printed Name	Your Signature	Date
_____	_____	_____
Counselor's Printed Name	Counselor's Signature	Date

In Case of Emergency

Below is the person that can be contacted in order to prevent harm or in case of emergency.

_____		
Name	Phone Number	Relationship

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Policies and Payment

Your therapist: Ashley Hubbard, LPC-Intern Full Rate: $60

Griffin Therapy Center requires 24-hour notice for all cancellations and rescheduling. If you do not provide 24 hours notice you will be billed $60 for the full cost of the counseling session. Insurance does not cover cancellations or missed appointments. Additionally, if insurance is filed and fails to pay, you will be responsible for all counseling fees.

A $25 late fee is assessed for fees not paid at the time of service. Overdue accounts will be charged for any collection fee plus a $70.00 processing fee.

For appointments, cancellations, or to reschedule please call Griffin Therapy Center at 940-765-6487 or email at appointments@griffintherapycenter.com. Phone messages will be returned with 24 hours.

I agree to the billing terms set forth above, and agree to the confidential storage of my card on file for the future use of billing and automatic drafting of payments for late-cancellation and no-show fees.

Name as it Appears on Card: _____

Card #: _____

Expiration Date:_____ 3-Digit Code:_____ Billing Zip Code: _____

_____ _____ _____

Your Printed Name Your Signature Date

Insurance Company: _____ Member ID: _____

Group Number: _____

Policy Holder's Name: _____ Your Relation to Policy Holder: _____

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HIPAA

HIPAA (Health Insurance Portability and Accountability Act)

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

Notice of Client Rights

• You have the right to receive full information from your counselor about his or her professional knowledge, skills, preparation, experience, and credentials.
• You have the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.
• You have the right to have explained to you how a therapy technique works as well as given an explanation for its intended purpose before it is employed.
• You have the right to refuse a particular therapy technique or method.
• You have the right to request restrictions on certain uses and disclosures of your counseling records. However, your counselor is not required to agree to a restriction you request.
• You have the right to request and receive confidential communications from your counselor by alternative means and at alternative locations. For example, if you don't want coworkers to know you are seeing a therapist, you can direct your counselor to telephone you only at home.
• You have the right to inspect and/or obtain a copy of your, or your minor child's, counseling record for as long as the record is maintained. Your counselor may deny your request.
• You have the right to request an amendment of your or your minor child's counseling record for as long as the record is maintained. Your counselor may deny your request.
• You generally have the right to receive an accounting of disclosures from your or your minor child's counseling record, for which you have neither provided consent nor authorization. Such disclosures are described under the section: "Limits of Confidentiality" above.
• You have the right to complain should you believe your privacy rights have been violated. In such cases first discuss the concern with your counselor to seek a satisfactory resolution, which may include a referral. If you are not satisfied with the outcome, you may file a written complaint to the Texas Department of Human Services (DHS) to further assist in resolving the matter:

Complaints Management and Investigative Section
P.O. Box 141369 Austin, Texas 78714-1369
Or call 1-800-942-5540 to request the appropriate form or obtain more information.

Your Printed Name	Your Signature	Date
Counselor's Printed Name	Counselor's Signature	Date

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Notice of Privacy Practices

- Your counselor has been and will always be totally committed to maintaining clients' confidentiality. He or she will only release information about your counseling records in accordance with federal and state laws and ethics of the counseling profession. This notice describes your counselor's policies related to the use and disclosure of your counseling records. Uses and disclosure of your counseling records for the purposes of providing services, providing treatment services, collecting payment, and conducting counseling operations are necessary activities for quality care. State and federal laws allow your counselor to use and disclose information from your counseling records for these purposes.
- Treatment—your counselor may need to use or disclose information from your counseling records to provide, manage, or coordinate your treatment or related services, which could include consultations with medical or mental health professionals and potential referral sources.
- Payment—your counselor may need to disclose information from your counseling records that is needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes.
- Counseling Operations—your counselor may need to use information about you to review his treatment procedures and business activity. This may involve supplying a government agency with statistical data. In such cases your name and personal information will not be divulged.
- Other uses or disclosure of your information that does not require your authorization or consent—these disclosures are described under the section: "Limits of Confidentiality" above

My signature below indicates I have been given a notice of this document for my personal keeping. In addition I have online access to the above HIPAA information at www.griffintherapycenter.com

_____	_____	_____
Your Printed Name	Your Signature	Date
_____	_____	_____
Counselor's Printed Name	Counselor's Signature	Date