

Griffin Therapy Center

EMPOWERMENT FOR HEALING



Adult Intake

Name _____ Date of Birth _____

Address _____ City, Zip Code _____

Cell # _____ Okay to call and leave messages? _____

Email _____

Okay to communicate via email*? _____ *Email is not considered to be a confidential medium of communication

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

Marital/Relationship Status _____

My family has a history of

Poor Communication Suicide Alcoholism Drug Addiction
 Hospitalization Eating Disorders Gambling Abuse
 Mental Illness (Depression, Bipolar Disorder, Anxiety) Other

I have had an unwanted sexual experience

Yes No Unsure

I have experienced

Emotional Abuse Sexual Abuse Physical Abuse Psychological Abuse
 Verbal Abuse Economic Abuse I am currently in an abusive relationship

Have you thought about harming yourself in the past? Yes No

Have you thought about harming yourself in the present? Yes No

Have you thought about harming other people? Yes No



Limits of Confidentiality

The law protects the relationship between a client and a psychotherapist, 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.

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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I have read and understand limits of confidentiality listed above.

Printed Name	Signature	Date
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Counselor's Printed Name	Counselor's Signature	Date
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Policies and Payment

Thank you for choosing The Griffin Therapy Center. The Griffin Therapy Center is a dedicated private practice counseling agency providing out-patient mental health care. Stacy Griffin is a Licensed Professional Counselor with a focus on couples and individual therapy. 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 holds 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.

Although your counseling session may be personal and intimate in nature, the relationship between you and your counselor is a professional one, not 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 protect your confidentiality by acknowledging you only if you approach us first. In the event that Hilary Harrington, LPC-Intern becomes incapacitated or dies, your records and treatment coordination responsibilities will transfer to Stacy Griffin, LPC-S.

For appointments, cancellations, or to reschedule please call Griffin Therapy Center at 940-765-6487 or email at GTCappointments@gmail.com. Phone messages will be returned with 24 hours. Phone messages left after 4pm Friday will be returned the following Monday. For emergencies, please call the Crisis Help Line at 972-233-2233 or the Teen Help Line at 972-233-8336.

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24-hour notice is required for all cancellations and rescheduling. If you do not provide 24 hours notice, you will be billed the full cost of the counseling session. If a fee is not rendered at the time of service, you will be responsible for a \$25 late fee. In the event that your account is overdue and turned over to our collection agency, the client or responsible party will be responsible for any collection fee charged to our office plus a \$70.00 fee. If insurance is filed and the insurance company fails to pay, you will be responsible for all counseling fees. Please be aware that insurance does not cover cancellations without 24-hours notice or missed appointments. Please make checks payable to: Griffin Therapy Center. A \$30 bounced check fee is applied to you if your payment is not accepted.

Individual and Couples Rate is \$60. I agree to the billing terms set forth above, and agree to store this card on file for the future use of billing. This includes automatic drafting of payments for late-cancellation and no-show fees.

Card Number: _____ Expiration Date: _____

3-Digit Code: _____ Zip Code: _____

Printed Name

Signature

Date

Counselor's Printed Name

Counselor's Signature

Date



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.

Printed Name

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

Printed Name

Signature

Date

Counselor's Printed Name

Counselor's Signature

Date