Stillwell Christian Counseling
Andrea Stillwell, LCSW
2301 Olympia Suite 100 Flower Mound, Texas 75028
940 300-7986

Client Information

Date:____________ **Counselor:**____________________

Client's Name: ____
First Middle Initial Last

Address: ____

City:__________________ State: ________________Zip: ____________

Social Security #: ____________ Date of Birth: ________ Email________________

Phone: (_____)______________ (_____)______________ (____)______________
Home Work Cell

Spouse /Guardian/Parent Information:

Name:____
First Middle Initial Last

Address (if different from client): ____

Social Security #____________ Date of Birth__________ Email: ______________

Phone: (_____)______________ (_____)______________ (____)______________
Home Work Cell

Other Information: **Dependents**: ____
Name Relation DOB

____
Name Relation DOB

____
Name Relation DOB

Church Affiliation: ____________________ Referred by: ________________

Insurance Information

(Note: Please present insurance card with this form to be photocopied. Thank you.)

Name of Insured: ____

Insured's DOB: __________ **ID#:** ________________ **Group#:** ________________

Insurance Carrier: ____

Address: ____

CITY:____________________**ST:** ____________**ZIP:** ____________

Benefit/Eligibility Phone Number: (____)______________ **Deductible:**______________

Insured's Employer: ____

Address: ____

City: __________**ST:** ________**ZIP:** ________ **Phone:** ________________

I authorize the release of any medical or other information necessary to process this claim.

____
Insured's or Authorized Person's Signature

I authorize payment of medical benefits to the provider of services. I understand that I am responsible for my bill, not my insurance company. I am aware that if my insurance company declines payment, I am responsible for my bill.

____
Insured's or Authorized Person's Signature

Confidentiality: Everything said here is protected by the confidentiality statutes of the State of Texas. That means that any information will not be disclosed without your written consent except in the following situations: (a) If you threaten grave bodily harm or death to yourself or another person, your counselor is required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to your counselor your knowledge of the physical or sexual abuse of a minor child by an adult or of an elder (over 65) by an adult, your counselor is required by law to inform the appropriate child welfare agency which may then investigate the matter; (c) if your counselor is required by a court of law (court order) to turn over records to the court or is ordered to testify regarding those records.

Appointments: Counseling sessions are 45-50 minutes. 24 hours notice must be given if canceling an appointment becomes necessary. You will be billed for the session if less than 24 hours notice is given. Payment is due when services are rendered, at the end of each session. SCC will agree to file insurance claims on out-of-network mental health benefits if the client has applicable insurance coverage. The client is responsible for any co-payments, deductibles, and non-allowed charges. It is the client's responsibility to know what their insurance policy covers and to make sure the deductible is met. The issue of fee and reimbursement will be discussed and determined by the client and counselor during the first session.

If client is under 18, I ______________________________________(please print), have legal custody and give my consent for counseling of the above named minor.

____

Signature of Parent or Guardian

All members of your family who are involved in counseling need to sign below, indicating understanding of these policies and procedures.

ACKNOWLEDGED:

Date: _____________________ **Client's Signatures:**_______________________________

____

____

Andrea Stillwell,LCSW ____

NOTICE OF PRIVACY PRACTICES (Client's Copy)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make a new Notice available upon request.

USES & DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

1. We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or other practitioner.
  - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within The Center for Christian Counseling, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of The Center for Christian Counseling, such as releasing, transferring, or providing access to information about you to other parties.

2. We may disclose to a family member, other relative, a close personal friend of yours, or any other person identified by you, the health information directly relevant to such person's involvement with your care or payment related to your health care.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission that is above and beyond the general consent that permits only specific disclosures. In those instances, when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your counseling notes. *"Counseling notes"* are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or counseling notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.

- **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Texas Department of Protective and Regulatory Services.

- **Health Oversight:** If a complaint is filed against us with the State Board of Examiners, the board has the authority to subpoena confidential mental health information from us relevant to that complaint.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case**.**

- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.

- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

PATIENT RIGHTS

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.

- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described previously). On your request, we will discuss with you the details of the accounting process.

QUESTIONS OR COMPLAINTS

For more information about our privacy policy or have questions or concerns, please contact us. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may complain to us using the contact information listed at the end of this Notice. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will provide you with that address to file your complaint upon request.

Contact Officer: Andrea Stillwell, LCSW
Telephone: 940 300-7986
Address: 2301 Olympia
Flower Mound, TX 75028

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, ____, have received a copy of this office's Notice of Privacy Practices.

____
Signature

____
Date

For office use only

We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Specify below)

____

____

QUESTIONS TO ASK YOUR INSURANCE COMPANY:

1. What are my Out of Network mental health benefits? ____
2. Do I have a deductible? If so, can it be combined with my medical deductible in order to meet it? How much of it have I met so far? ______________________________
3. What is the percentage that my insurance pays and what is the percentage that is my copay? ___________________
4. How many visits are allowed per calendar year? ________
5. Do I need to be pre-certified (call before being seen by counselor)? If so, how often do they have to be called (how many visits allowed before having to call again)?

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Stillwell Christian Counseling

Name______________________________________ Date ______________________

SS#_______________________________________ Date of Birth _________________

Please complete the following questions as thoroughly as you are able. This information will help assess and provide the most appropriate treatment.

Why are you seeking counseling at this time? ___________________________________
____
____

What do you feel is the primary problem needing to be addressed? _________________
____
____

What other symptoms (if any) are you concerned about? __________________________
____
____

Have you sought counseling for this or any other problem in the past? Yes or No
If yes, please list previous therapists, duration of treatment, and outcome of treatment:
____
____
____
____

Have you ever been diagnosed with a psychiatric disorder? Yes or No If yes, please list any diagnoses, the year you were diagnosed and the diagnosing clinician:
____
____
____

Are you currently taking any prescription medications? Yes or No If yes, please name the prescribing physician, current medication and dosages, along with any side effects you may be experiencing:
____
____
____
____

Have you ever been hospitalized for a psychiatric or substance abuse disorder?
Yes or No If yes, please list facilities, duration of treatment and treatment outcome:
____
____
____
____

Name ________________________

Are you now, or have you ever been addicted to any prescription or non-prescription drugs, including alcohol? Yes or No If yes, please list ________________________

____

____

Please note any compulsive types of behaviors as they relate to food, spending, sex, gambling, etc.

____

____

____

Please indicate your current relationship status below:
Single Married Divorced Widowed Cohabiting Other

If you are currently in a relationship, please describe it and indicate if it is a supportive one. If you are not currently in a relationship, how long has it been since your last one?

____

____

____

What are your strengths in a relationship or friendship? ___________________________

____

____

What are your weaknesses in a relationship or friendship? ______________________

____

____

Do you feel your support system is adequate? Yes or No Who or what are your sources of support?

____

____

____

____

If you have children, please list their names, ages, and indicate if they live in your household:

NAME	AGE	LIVING ARRANGEMENTS

Are any of your children currently experiencing any problems? ___________________

____

____

 Name ____________________

Please list our siblings:

NAME	AGE	WHERE DO THEY LIVE?
____________________	_________	______________________________
____________________	_________	______________________________
____________________	_________	______________________________
____________________	_________	______________________________
____________________	_________	______________________________

Have your siblings experienced any problems? ______________________________
____

Is your mother living? Yes No Is your father living Yes No
Are your parents currently together? Yes No If no when did they divorce, separate, or become widowed?
____
____
____

Is there a history of mental health disorders or substance abuse in your family?
Yes No If yes, please indicate details for each family member:
____
____
____
____

List five words that describe your mother when you were a child: _________________
____
____

List five words that describe your father when you were a child: _________________
____
____

What is your relationship with your parents like today? _________________________
____
____

What is your relationship with your siblings like today? _________________________
____
____

What educational experience or degrees do you have? __________________________
____
____

Are you currently employed? Yes No Please describe career/job history below:
____
____
____

Name ___________________________

What are your career goals? ____

Have you ever been verbally, emotionally, physically or sexually abused? Yes No
If yes, please indicate type of abuse, by whom, when it started and when it ended.

Do you have a history of suicide attempts? Yes No If yes, please explain below:

Are you currently feeling suicidal or are you in crisis at this time? Yes No
If yes, please explain: ____

What goals would you like to meet in therapy? _______________________________

Please list three of your strengths. ____

How would you describe yourself? ____

What do you believe spiritually? ____

Do you desire to incorporate your spiritual beliefs into your counseling? Yes No
Please explain: ____

Is there anything else that would be helpful to know? __________________________