GENETTE STANTON THERAPY, LLC – CLIENT INFORMATION FORM
Genette Stanton, MEd, LPC, NCC, CART

Patient's Name: _____
Last First Initial

Birth Date: _____ **Social Security #** _____

MEDICAL INFORMATION:
Referred by: _____ Current reason for Counseling: _____
Previous counseling: For what?_____When? _____
Where? _____ With whom? _____ How Long? _____
What was the Outcome?_____
Please list any current Medications: _____
Have you experienced a traumatic pregnancy loss?_____
Medical Problems/History: _____
Current use of Alcohol (how much, how often) _____
Illicit Drug use in the past 12 months? (how much, how often) _____
Any history of mental illness, emotional or physical abuse, or any substance abuse in you or your spouse's family? (If yes, please list)_____

PLEASE READ AND SIGN OR INITIAL BELOW
Some people want to have Christian ideas and philosophy integrated into their counseling. If you would like this, please initial. Yes _____ No____

I consent to be counseled. I understand that I have the right to confidentiality, except in situations where there are homicidal or suicidal threats, and or neglect or abuse of a child or an elderly person. If there is a life or death emergency, I will call 911. I have read and understand my rights and limitations per HIPPA laws and regulations (attached)

Signature: **X**_____ Date: _____

PAYMENT INFORMATION

All payments are due and collected at the beginning of each session. The fee for Counseling and/or Consultation services is $120 for the initial 50 minute session, and then $100 for each 50 minute sessions thereafter. We accept cash, check, or credit card. In the event of a returned check, the credit card on file will be charged with the addition of any relevant bank charges incurred.

I understand that if I cancel my set appointment less than 24 hours before that appointment, I will be charged $60 for that session and may lose any set appointment times that I may have.

Insurance, EAP, or Other Payer:

Insurance - If you are using any type of "other payer" such as insurance

☐ < If this applies to you, c heck here

1. I will need a copy of your insurance card (front and back) and/or your authorization letter (if you have one).
2. Any co-payment, or "client participation fee" such as in a co-insurance arrangement, must be paid at the beginning of the session.
3. If the insurance company or "other payer" fails to make their payments, such as if you have a deductible, you will be responsible for the contracted fee. If the insurance starts paying after the deductible is met, your fee will be the contracted rate of the insurance company, or other payer from when the insurance starts paying.

EAP (Employee Assistance Programs) – If you were referred by your company's EAP:

☐ < If this applies to you, c heck here

1. We need to have your authorization number or copy of your authorization letter.
2. Please read and sign the "Statement of Understanding"
3. Since the provider only gets paid at the end of the authorized number of sessions, you are asked to schedule all of your sessions during the initial consultation.

INSURANCE INFORMATION: Employer: _____ **Note: We will need a**

Insurance Company: _____ **copy of your insurance**

Member Id. _____ **Group #** _____ **card and credit card**

Authorization #: _____ **Number of Sessions approved:** _____

Credit Cards: You are required to keep a valid credit card on file. This card will be used in the event of a late cancellation.

Name on Credit Card: _____Card number: _____

Expiration Date: _____Amount: $ _____ Customer Code on back of card: _____ Card Holder's Zip Code: _____

I have read and understand the above payment information. If I am using a credit card, I authorize you to charge for my fee, my co-payment, participation fee (co-insurance fee), or late cancelation fees.

Signature: **X**_____ Date: _____

Attachment – HIPPA Statement

This form also contains information about a federal law that affects your privacy rights. This law, called HIPAA (Health Insurance Portability and Accountability Act), regulates the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. HIPAA requires that we give you a Notice of Privacy Practices (the Notice). The Notice, which is attached to this Agreement, explains HIPAA's application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Please take home the Notice and read it before your next session; you and your therapist can discuss any questions you may have about it next time.

Appointments
Appointments can be scheduled by calling (713) 819-8663 or online via the link on my web site at www.stantontherapy.com. It may be necessary to leave a message. *If you need to cancel an appointment please notify me at least 24 hours before the session to avoid charges as discussed in the Client Information Form.*

Telephone Calls
If you receive my voicemail, please leave a message and I will get back to you by the following business day (M-F). Phone, email, and text are acceptable for the purposes of scheduling appointments. However, calls relating to treatment will be billed at $60 for all calls lasting longer than 15 minutes.

Emergencies
In emergencies, please call 9-1-1 or go to your nearest hospital emergency room. An emergency is generally a situation in which you are in danger of harm or have hurt yourself or someone else.

Confidentiality and Files
The laws governing confidentiality can be quite complex. The attached Notice explains some specific Patient Rights that you have under the HIPAA law. I will maintain a Clinical Record file on your case, which is the property of Genette Stanton Therapy, LLC You may examine and/or receive a copy of your file *if* you request it in writing *and* the request is signed by you *and* dated not more than 60 days from the date it is submitted. There may be a charge for writing reports or for copying materials. In most situations, Genette Stanton Therapy, LLC can release information about your treatment to others *only* if you sign a written authorization form for each release. However, I am a *mandated reporter* and there are a few situations where I am required to disclose information to authorities. These situations are listed on page 2.

Your signature on this agreement is written, advance consent for the following releases of information:

- Your therapist may occasionally find it helpful to consult with other health and mental health professionals about a case. During consultations, your therapist makes every effort to avoid revealing the identity of patients. The other professionals are also legally bound to keep the information confidential. The therapist will note all consultations in you Clinical Record.

- Your therapist may find it helpful to receive or exchange information with your primary care physician or other health and mental health professionals who are currently treating you. Your signature on this Agreement is written, advance consent for me to release information to these professionals. A record of any disclosure will be kept in your Clinical Record.

_____ Check here if you do NOT wish me to release any information to other mental health and health professional who are currently treating you.

There are some situations where Genette Stanton Therapy, LLC is required to disclose information without your consent or authorization:

- If a client is clearly likely to seriously harm him/herself, we may be required to take action to prevent self-destruction.

- If there is a clear risk that a client plans to seriously harm another person, we may have a duty to warn the potential victim; or disclose the risk to appropriate public authorities.

- If a therapist suspects that abuse of a child or senior citizen may have taken place, the therapist is required to report the suspected abuse to the Department of Social and Health Services.

- If the client is a minor, younger than age 17, both parents have access to the minor client's complete Clinical Record, including Psychotherapy Notes, unless there is a court order prohibiting one of the parents from access.

- If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis, or treatment, such information is protected by the counselor-client privilege law. Genette Stanton Therapy, LLC cannot provide any information without your (or your personal or legal representative's) written authorization. However, if a court **orders or subpoenas** Genette Stanton Therapy, LLC to disclose information, we are required by law to provide it. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

- If a client files a complaint or lawsuit against Genette Stanton Therapy, LLC or any of its staff, Genette Stanton Therapy, LLC may disclose relevant information regarding that patient in order to defend itself.

- If a client files a worker's compensation claim, the client must sign an authorization so that Genette Stanton Therapy, LLC may release the information, records, or reports relevant to the claim.

- Genette Stanton Therapy, LLC may present disguised case material in seminars, classes, or scientific writings. In this situation all identifying information and Protected Health Information is removed, and client confidentiality and anonymity is maintained.

Your signature below indicates that you have read this Agreement and agree to its terms, and also serves as an acknowledgement that you have received the HIPAA Notice of Privacy Practices described above.

X_____ _____

Signature of Client or Responsible Party Date