(Confidential Client Information)

TEXAS WESLEYAN UNIVERSITY COMMUNITY COUNSELING CENTER

PERSONAL HISTORY

Today's Date ____/____/_____

First name _____ Last name _____ Age ____ DOB ____/____/_____

Home Phone _____/_____/_____ Mobile Phone _____/_____/_____ Email_____

Street Address _____ City _____ State _____ Zip Code _____

Occupation _____ Who suggested counseling to you? _____

Emergency Contact – Full Name _____ Phone _____/_____/_____ Relationship _____

Legal Gender: Male
(Circle) Female
Transgender M-F
Transgender F-M
Other

Gender Identity**: (optional)**

_____

Pronouns: **(optional)**

_____

Sexual Orientation**: (optional)**

_____

Race: Undefined
(Circle) American Indian/
Alaska Native
Asian
Black/African-American
Hawaiian Native/
Pacific Islander
Hispanic/Latino
Multiracial
White/Caucasian

Religion: None
(Circle) Protestant
Catholic
Jewish
Mormon
Orthodox
Muslim
Hindu
Buddhist
Atheist/Agnostic
Christian
Other

Marital Status: Undefined
(Circle) Married
Single
Widowed
Divorced
Separated
Common Law
Living Together
Partner
Engaged

****

➔**We <u>DO NOT</u> perform "forensic services" *(child custody, disability claims, assessment for legal purposes, psychological/psychiatric evaluations)* and <u>CANNOT</u> provide forensic opinions, reports, assessments, or recommendations according to Rule 465.18, Texas Administrative Code, Title 22.**←

I have read/understand concerning "forensic services". _____ ***Initials; Date*** _____/_____/_____

****

Briefly describe the concern(s) that bring you to counseling: _____

_____

Briefly describe what change(s) you want to see as a result of counseling: _____

_____

Please put an ***X*** on the scale below to indicate the severity of the problem:

0_____ 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ 8_____ 9_____ 10_____

No Problem **Moderate** **Serious** **Severe** **Very Severe**

Prior counseling experience? When, where, for what reason. Are/were you on any **medication(s), please list**?

_____

Personal History form completed by: _____ **Date** _____/_____/_____

(Signature)

***Counselor Use Only:** *Established per session fee: _____ Initial: _____ Date: _____/_____/_____*

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TEXAS WESLEYAN UNIVERSITY COMMUNITY COUNSELING CENTER

SLIDING FEE SCALE

PLEASE READ

Finances should not be a stress factor for receiving counseling services. **The inability to pay does not disqualify anyone from receiving counseling.**

❑(√) ***For Texas Wesleyan student, alumni, faculty or staff, counseling is no charge.***

To estimate fee – Find **Annual Income** range **(A)**, find **Household size (B)**
CIRCLE amount below **Household size (B)**

****If this amount is not reasonable, complete bottom of page****
(Your counselor will work with you to create a reasonable fee structure)

Household Size (B)
(Number of people living in the household)

(A) *Annual Income*	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
$0-15,000	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**
$16,000-25,000	**15**	**15**	**15**	**14**	**13**	**12**	**11**	**10**	**10**
$26,000-30,000	**20**	**20**	**20**	**18**	**16**	**15**	**12**	**10**	**10**
$31,000-40,000	**25**	**25**	**25**	**22**	**20**	**17**	**15**	**10**	**10**
$41,000-50,000	**30**	**30**	**30**	**25**	**20**	**17**	**15**	**10**	**10**
$51,000-60,000	**35**	**35**	**35**	**30**	**25**	**20**	**15**	**10**	**10**
$61,000-70,000	**40**	**40**	**40**	**35**	**30**	**25**	**20**	**10**	**10**
$71,000+	**50**	**50**	**50**	**45**	**40**	**35**	**20**	**10**	**10**

****

(Complete **ONLY** if you need a fee reduction)

➔ FEE REDUCTION REQUEST ←

(Must be signed by Director)

❑ **I would like to request consideration for fee reduction and can presently pay $_____ per session.**

_____/_____ _____/_____/_____
(Client **Printed Name**) (Client **Signature**) (Date)

_____ _____/_____/_____
(Clinical Director **Signature**) (Date)

(Confidential Client Information)

TEXAS WESLEYAN UNIVERSITY COMMUNITY COUNSELING CENTER

***COUNSELING* SERVICE AGREEMENT (p. 1)**

If the primary client is a minor OR if minor(s) are present in ANY session, the parent/guardian/ conservator must read, initial and sign THIS form AND Requirements for Parenal Consent of Minor(s) form.

If the primary clients are an adult couple, BOTH participants must read, initial and sign THIS form.

THE COUNSELING PROCESS

Counseling provides an opportunity for self-examination and positive change providing benefits in reduction in distressful feelings, better relationships, and solutions to problems.

I(We) have read and understand the benefits of "The Counseling Process". _____/_____ ***Initial(s)***

APPOINTMENTS – CANCELLATIONS, NO SHOWS, RESCHEDULING

Sessions will last **45-50 minutes** and are voluntary unless mandated to receive counseling. **If you are late for your appointment, the session will still end on time.** If you encounter time constraints, set the appointment for the next hour if that time is open. To discontinue counseling or change student counselors, please discuss this with your counselor.

24 HOURS CANCELLATION NOTICE and RESCHEDULING WITHIN *48 HOUR IS REQUIRED*

Do this so your next available appointment will be at your regular time. Missing a scheduled appointment and not rescheduling within 48 hours will result in your file being closed. As a courtesy, your counselor **may** call and leave a message to the number you provide to call and reschedule. The center will not communicate clinical information via e-mail or cell phone. Scheduling is done by *clinic phone ONLY*.

I(We) have read and understand the "Appointments - Cancellation, no show and rescheduling" and the "24 hour cancellation notice and rescheduling within 48 hours required" and will contact the center by phone only. _____/_____ ***Initials(s)***

DIGITAL RECORDING/LIVE OBSERVATION

Student counselors are supervised by licensed professional counselors and licensing board-approved supervisors and are under peer review for providing valuable feedback to improve counseling skills. All sessions at the center are digitally recorded on a secure server and password protected. Some sessions may be observed live behind a one-way mirror as well.

I(We) have read and understand the policy on "digital recording, live observation, and consent to digital recording and/or live observation during my(our) counseling sessions. _____/_____ ***Initial(s)***

►AT THE COMPLETION OF COUNSELING, YOUR FILE WILL BE CLOSED AND ALL DIGITALLY RECORDED SESSION(S) WILL BE ERASED◄

(Confidential Client Information)

TEXAS WESLEYAN UNIVERSITY COMMUNITY COUNSELING CENTER

COUNSELING SERVICE AGREEMENT (p. 2)

CONFIDENTIALITY AND COUNSELING RECORDS

Student counselors and/or supervisors may exchange any/all information obtained with counseling staff. All digital recording is confidential according to Texas State law and ethical guidelines of Texas counseling licensing boards - *Texas State Board of Examiners of Professional Counselors, and Texas State Board of Examiners of Marriage and Family Therapists, American Association for Marriage and Family Therapy and American Counseling Association.* All digitally recorded material is stored on a secure server and password protected. Under HIPAA **disclosure of counseling records is permitted by law without your authorization or consent when ANY of the following conditions exist:**

1.) ***Reasonable suspicion of abuse/neglect*** *of children/elderly reportable to Child/Adult Protective Services; 2.)* ***Where you present a serious danger/threat to yourself or others*** *(homicide/suicide), reportable to* ***anyone*** *who is reasonably able to prevent or lessen the danger/threat; 3.)* ***If your records are under subpoena*** *by a court of law.*

I(We) have read and understand the policy on confidentiality and counseling records. _____/_____***(initials)***

I (We) also understand that if I request my records, none will be transmitted electronically or by fax. After written consent is obtained, I will physically pick up my records at the Texas Wesleyan University Community Counseling Center within fifteen (15) days of my request during normal business hours. _____/_____***(initials)***

I (We) give my consent to be called on my cellular phone, or sent a text by my counselor to remind me of my appointment. I understand that no clinical information will be transmitted through these devices. _____/_____***(initials)***

RESEARCH

Evaluation information that may be used in current or future research projects. Participation in this research is voluntary and you may withdraw consent which will in no way affect our service to you. Publications resulting for this research **will not contain any identifying information and your confidentiality will be strictly maintained.**

I(We) have read and understand the research statement and consent my(our) personal Information being used for research purposes. _____/_____***(initials)***

I(We) have read and understand this entire Counseling Service Agreement. (Couples - both print and sign name)

_____/_____ _____/_____

(**Print** Adult Client **and** Spouse/Partner Name(s) (Adult Client/Spouse **and** Partner **Signature(s)**

_____ _____

* If Client(s) is a minor, **Print** minor Name(s)* *If Client(s) is a minor, **Parent/guardian/conservator must Sign)***

_____ _____

(**Print** Student Counselor/ Counselor Name) (Student Counselor/Counselor **Signature**)

_____/_____/_____ _____/_____/_____

(Date) (Date)

***For Office Use Only*:** Student counselor must acknowledge having discussed verbally and in-person with client(s) each major section of this CSA. Please write your initials AFTER discussing this document with your client(s) and answering any questions he/she/they may have. **Counseling Process:** _____ (initial) **Appointments/Cancellation Policies:** _____ (initial) **Digital Recording:** _____ (initial) **Confidentiality Statement, including exceptions**: _____ (initial) **Research Policies**: _____ (initial)

HIPAA Privacy Statement

The Texas Wesleyan University Community Counseling Center: Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Texas Wesleyan University Community Counseling Center and its affiliated entities (collectively "The Texas Wesleyan University Community Counseling Center") use health information about you for treatment, to obtain payment for treatment, to evaluate the quality of care you receive, and for other administrative and operational purposes. Your health information is contained in a medical record that is the physical property and responsibility of The Texas Wesleyan University Community Counseling Center. The Texas Wesleyan University Community Counseling Center is required by law to maintain the privacy of health information about you and provide you with this notice of our legal duties and privacy practices with respect to your health information ("Notice of Privacy Practices" or "Notice"). We must abide by the terms of this Notice currently in effect. The Texas Wesleyan University Community Counseling Center reserves the right to change the terms of this Notice, our privacy practices, and to make the new provisions effective for all protected health information we maintain. You may contact the Texas Wesleyan University Community Counseling Center location or the Texas Wesleyan University Community Counseling Center's Chief Privacy Officer at the address or phone listed below to obtain a revised Notice of Privacy Practices.

Your Health Information Rights: You have the following rights with respect to health information about you.

Right to Copy of Notice of Privacy Practices. You have the right to a paper copy of our Notice at any time. Please contact the Texas Wesleyan University Community Counseling Center location or the Texas Wesleyan University Community Counseling Center's Chief Privacy Officer at the address or phone listed below to obtain a copy.

Right to Inspect and Copy. You have the right to inspect and/or obtain a copy of the health information about you that we maintain. **Your request must be in writing**. You may pick up such documents during normal working hours at the Texas Wesleyan University Community Counseling Center **no more than fifteen days after your request.**

Right to Amend. If you feel that health information about you that we maintain is inaccurate or incomplete, you have the right to request that we amend the information. You may request an amendment as long as we maintain the information. We may ask that you submit it in writing and include a reason supporting the request. In certain circumstances, we may deny your request. If your request is denied, we will explain our reasons in writing. You may submit a statement explaining why you disagree with our decision to deny your amendment request. We will share your statement when we disclose health information about you that we maintain in certain groups of records.

Right to an Accounting of Disclosures. You have the right to request an accounting or detailed listing of certain disclosures of health information about you. The time period covered by the accounting is limited to six years prior to the date of your request. Your request must be in writing. If you request an accounting more often than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information about you that we use or disclose. Your request must be in writing. We are not required to agree to your request. However, we must agree not to disclose health information about you to your health plan if the disclosure is for payment or health care operations and relates to a health care item or service which you paid for in full out of pocket. If we agree to your request, we will comply with it unless the information is needed for emergency treatment. We will notify you if we are unable to agree to a requested restriction.

Right to Revoke Authorization. You have the right to revoke your authorization to use or disclose health information, except to the extent that action has been taken in reliance upon your authorization. Your request must be in writing

Right to Request Alternative Method of Communication. You have the right to request that we communicate with you about mental health matters in a certain way or at a certain location. Your request must be in writing. We will accommodate all reasonable requests.

Right to Notification of Breach. You have a right to be notified if your files are affected by a breach of unsecured health information.

Complaints: If you believe your privacy rights have been violated, you may complain to The Texas Wesleyan University Community Counseling Center and to the Secretary of the Department of Health and Human Services. You may make a complaint to below. You will not be retaliated against for filing a complaint.

Individuals Involved in Your Care or Payment for Your Care. We may disclose to a family member, other relative, close personal friend or any other person you identify, health information about you directly relevant to that person's involvement in your care or payment related to your care with your permission only.

Required by Law. We may use and disclose health information about you as required by federal, state, or local law. For example, we may disclose health information for the following purposes: (1) for judicial or administrative proceedings pursuant to legal authority; (2) to report information related to victims of abuse, neglect, or domestic violence; and (3) to assist law enforcement officials in their law enforcement duties.

Public Health. We may use or disclose health information about you for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Health Care Oversight. We may use or disclose health information about you to a health oversight agency for oversight activities authorized by law, such as audits, investigations, and inspections.

Research. We may use or disclose health information about you to researchers if an institutional review board or privacy board has reviewed and approved the research proposal, and established protocols to ensure the privacy of your health information.

Health and Safety. We may use or disclose health information about you to avert a serious threat to your health or safety or any other person pursuant to applicable law.

Government Functions. We may use or disclose health information about you for specialized government functions, such as protection of public officials, national security and intelligence activities, or reporting to various branches of the armed services.

Correctional Institutions. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclosure health information about you. Such health information will be disclosed to the correctional institution or law enforcement official when necessary for the institution to provide you with health care and to protect the health and safety of others.

Affiliated Covered Entity. We are part of an affiliated covered entity with other entities that are under common ownership or control. The entity treats itself as a single entity for purposes of using and disclosing health information about you.

Uses or Disclosures of Your Health Information Based Upon Your Written Authorization

Psychotherapy Notes. We must obtain your written authorization for most uses and disclosures of psychotherapy notes.

Marketing. We must obtain your written authorization to use and disclose health information about you for most marketing purposes.

Other Uses. Other uses and disclosures of health information about you, not described above, will be made only with your written authorization. You may revoke your authorization, at any time, in writing, except to the extent that we have taken action in reliance on the authorization.

Other Applicable Laws.
This Notice is provided to you as a requirement of the Health Insurance Portability and Accountability Act ("HIPAA"). There are other laws that may apply and limit our ability to use and disclose health information about you beyond what we are allowed to do under HIPAA.

State Laws. We will comply with your state's laws if they provide you with greater rights over your health information or provide for more restrictions on the use or disclosure of your health information.

Confidentiality of Alcohol and Drug Abuse Patient Records.
The confidentiality of alcohol and drug abuse patient records by us is protected by Federal law and regulations. Generally, we may not say to a person outside our alcohol and drug treatment program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser, unless:
(1) You consent in writing;
(2) The disclosure is allowed by a court order; or
(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by the program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. For more information, see 42 U.S.C 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 C.F.R Part 2 for Federal regulations.

Contact Information: If you have any questions, requests, or concerns about your Texas Wesleyan University Counseling Center-related health information rights or our use and disclosure of health information, please contact: Chief Privacy Officer, Scott Methvin, M.Ed, The Texas Wesleyan University Community Counseling Center, 3110 E. Rosedale, Fort Worth, TX 76105.

Prepared for the Texas Wesleyan University Community Counseling Center's clients, effective August 1, 2014.

Your signature below is only acknowledgement that you have received this Notice of Privacy Practices:

ADULT Client/Guardian Signature: _____ **DOB:** _____/_____/_____

Other ADULT Client Signature: _____ **DOB:**_____/_____/_____

Other ADULT Client Signature: _____ **DOB:**_____/_____/_____

IF MINOR IS PRIMARY CLIENT, *PRINT NAME ONLY*: _____ **DOB:** _____/_____/_____

____/_____/_____
(Today's Date)