

NEW PATIENT REGISTRATION

Grace Point Counseling Center

This form and all other information you give us about yourself is confidential.

PLEASE FILL OUT THE FOLLOWING INFORMATION AS IT APPLIES TO THE CLIENT:

DATE: _____ COUNSELOR: _____
NAME: _____ DOB: _____ SEX: _____ AGE: _____
HM PHONE#: _____ WK#: _____ CELL#: _____
HOME ADDRESS: _____ CITY: _____ ZIP: _____
SOCIAL SECURITY#: _____ MARITAL STATUS: _____
SPOUSES NAME _____ DOB: _____ CELL#: _____
IN AN EMERGENCY, CONTACT: _____ PHONE: _____
RELATIONSHIP TO EMERGENCY CONTACT: _____

PLEASE FILL OUT THE FOLLOWING INFORMATION AS IT APPLIES TO PARENT/GUARDIAN OR INSURED : (IF DIFFERENT THAN CLIENT)

NAME: _____ DOB: _____ SS#: _____
HM PHONE#: _____ WK#: _____ CELL#: _____
HOME ADDRESS: _____ CITY: _____ ZIP: _____
RELATIONSHIP TO EMPLOYEE: _____

HOW DID YOU HEAR ABOUT OUR CENTER?

Church Friend Spouse Yellow Pages Relative Internet
 Seminar Work Brochure Minister Other _____

PROBLEM AREA(S):

Marital/Relationship/Family Conflict Emotional Medical Career Legal Financial
 Alcohol/Drug Problem with Supervisor/Employee/Co-Worker Other _____

WHY DID YOU COME TO SEE US? _____

MEDICAL INSURANCE INFORMATION: EMPLOYER: _____

NAME OF INSURANCE COMPANY: _____ SUBSCRIBER ID: _____
NAME OF INSURED: _____ SOCIAL SECURITY#: _____
DOB: _____ GROUP ID: _____ PHONE# TO VERIFY COVERAGE: _____

I, _____ hereby authorize Grace Point Marriage and Family Center to disclose diagnostic information
(name of client)

to: _____ The disclosure of information authorized herein is required to verify insurance benefits and such disclosure
(name of insurance company)

shall be limited to diagnostic information. I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and if not revoked this consent shall continue from the date signed without express revocation.

Client Signature

Date

CONFIDENTIALITY

The information you give to us is confidential. We will not release information to anyone, including your employer or family member(s) without your written consent. The exceptions, as prescribed by law, to confidentiality are by court order, or in those situations that are life threatening, involve child abuse or neglect, certain cases of the abuse of a vulnerable adult, or the commission or threat of crime on these premises. If at any time you have concerns regarding your process, you are encouraged to discuss the matter immediately.

Since appointments are in high demand, please help us meet the needs of others by keeping your appointments. There will be a charge at your full fee price for a late or no show cancellation or for those who do not notify us 24 hours in advance.

I have read this form and understand its contents. I consent to utilize Grace Point Counseling Center's services in accordance with the above guidelines.

Client Signature

Date

As a parent, guardian or managing conservator, I have provided the divorce decree or appropriate documentation if necessary hereby authorize Grace Point Counseling Center to provide services for _____

(Name of minor)

Parent, Guardian, or Managing Conservator*

Date

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INFORMED CONSENT FOR TREATMENT

Grace Point Counseling Center (GPCC) is committed to providing quality services to our clients and the information necessary to be informed about the treatment process. *If you have any questions regarding anything on this form, please discuss them with your counselor before signing.*

PHILOSOPHY

The Grace Point Counseling Center (GPCC) is a ministry of The Woodlands United Methodist Church. It operates under the belief that sensitivity, professionalism, and respect for human dignity are fundamental to addressing the spiritual and emotional needs of couples and families. The staff at the Grace Point Counseling Center will respect the beliefs, whatever they may be, of all clients. We see people from many different faith traditions and believe that through creating authentic relationships individuals can integrate their beliefs into a healthier emotional and spiritual lifestyle.

COUNSELING

The relationship that exists between a counselor and a client is professional rather than social. Therefore, contact with your counselor will only take place in the provision of a professional service. At times, you or your family members may receive more than one clinical service at the GPCC. This can mean that several counselors are working with you or your family at the same time. GPCC clinical staff will meet regularly to discuss progress and treatment issues. In order to assist in the needs of your family, it may be necessary to refer you to other agencies or professionals. If necessary, we will assist you in facilitating these referrals. Your written consent is required to disclose any information about you or your family to individuals outside of the GPCC

Counseling is an opportunity for healing and personal growth. We believe that individuals can possess the ability to do what is necessary to take an active role in this process. The length of time needed for counseling and the amount of intervention required varies with each individual. In order to receive the maximum benefits of counseling, *your regular attendance and participation is imperative.* In most cases, counseling is completely voluntary and you can discuss ending your counseling relationship at any time. However, we recommend that, when possible, all counseling relationships be ended in an appropriate and therapeutic manner, generally requiring a final session to allow for closure. During the counseling process your counselor may recommend books for you to read, offer handouts, or use techniques to facilitate personal growth. We encourage you to discuss with your counselor any approach, technique, or practice with which you have questions, concerns, or need clarification. Counseling can be a difficult experience for some people. The disclosure of past hurts or current struggles can cause a temporary increase in depressive or anxious symptoms. If this occurs for you, please discuss the symptoms with your counselor. We at the Grace Point Counseling Center are honored that you have chosen us to assist you in your personal growth.

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APPOINTMENTS

Counseling services are by appointment only. You are responsible for keeping your appointments and arriving on time. GPCC retains the right to discontinue services if you have missed more than two consecutive appointments, if you do not pay your counseling fees in a timely manner, if you continually refuse to comply with treatment recommendations, if it is clear that you are receiving no benefits from counseling, if you exhibit abusive behavior, if you engage in criminal behavior on the premises, or if you knowingly violate the confidentiality of GPCC clients; e.g. – group settings.

GPCC cannot allow unattended minors in the waiting room. There are no nursery services available during counseling appointments. If you do not have child care arranged, please call to reschedule your appointment.

Parents and/or guardians must remain in the waiting room during their child's counseling session.

CLINICAL STAFF

Counseling sessions are provided by licensed counselors, counselors holding a Master's degree with a "licensed intern" designation, or practicum students seeking a graduate degree in the counseling field. Counselors with a "licensed intern" designation and practicum students are under supervision by a licensed counselor on staff. Counseling sessions at the GPCC may be video and/or audio taped. Taped sessions are for training and supervision purposes and will be handled confidentially. Sessions can only be taped with your signed consent. Taped sessions will be erased after they have been viewed for training or supervision. At times, and with your permission, a Master's level practicum student may "sit in" with your regular counselor for observation and training purposes.

CONFIDENTIALITY

Confidentiality is described as keeping private the information shared between a client and his/her counselor. Counseling sessions at GPCC are strictly confidential. Information regarding your counseling sessions will not be discussed, without your permission, beyond the clinical staff at GPCC.

The following describes those situations in which GPCC are required to break confidentiality.

- Instances of suspected or known child abuse, abuse to the elderly or disabled
- Sexual exploitation by other counselors
- Misconduct or unethical behavior by staff while in a hospital or residential unit
- Knowledge that a client is a danger to himself/herself or to someone else.

In any of the previous situations the counselor must report the suspicion or knowledge of abuse to the proper licensing board or authorities. Additionally, court orders requiring the release of counseling records may result in the release of those records. In reference to the treatment of minors, risk-taking behavior that is considered detrimental to the safety of the minor or others will be shared with the minor's parent(s) and/or guardian.

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Participants who are in couples and/or family counseling and are or become involved in individual counseling will have discretion over their own information becoming part of a counseling session involving other family members. Individuals involved in group counseling are required to maintain the confidentiality of the other group members outside of the group sessions.

COMMUNICATION

You can reach your counselor by calling GPCC. If your counselor is unavailable, or you have called after hours, you can leave a message. Your call will be returned at your counselor's earliest convenience. If you are in crisis, and it is after hours, please call one of the following numbers:

- Tri-County 24 Hour Crisis Line 1-800-659-6994
- 911

CONSENT TO DISCLOSE INFORMATION

At times, your counselor may need to consult with other professionals or agencies on your behalf. Your signed consent to disclose information to other agencies and/or individuals will be required. Exceptions may include a subpoena by the court of law. If you have received or are currently receiving mental health services and/or psychotropic medications from another health care provider we may request your consent to speak with those professionals and/or obtain copies of previous treatment records. Providing treatment may depend on our ability to communicate with these professionals.

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CONCLUSION

I have read and understand the above information and agree to voluntarily enter myself and/or my child into counseling services at Grace Point Counseling Center. I have had the opportunity to discuss all of the aspects of treatment fully, have had my questions answered, and understand the treatment planned. I further understand the limits of confidentiality and understand that those limits also apply in the treatment of a minor. If I am the parent or legal conservator or guardian of a minor, my signature below indicates my consent to their treatment. Additionally, I have provided the most recent legal documentation to indicate that I have managing conservatorship, legal guardianship, and/or the right to consent for treatment for the minor named below. I agree to promptly notify the counselor should my legal status over this minor change.

Client or Parent/Legal Guardian

Minor

Counselor

Date

Clinical Manager/Supervisor

Date

COUNSELING GOALS:

WHAT WOULD YOU LIKE TO SEE ACCOMPLISHED IN YOUR COUNSELING?

1. _____

2. _____

3. _____

4. _____

**NEW PATIENT REGISTRATION
NOTICE OF PRIVACY PRACTICES**

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.

We are required by The Health Insurance Portability & Accountability Act of 1996 (HIPPA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by the practice and of your individual rights and the practice's legal duties with respect to confidential information.

Ways in Which We May Use and Disclose your Protected Health Information:

We may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment, and healthcare operations.

- **Treatment** means providing, coordinating, or managing mental health care and related services. *For example* – use or disclosure by the health care provider in training programs in which “students, trainees, or practitioners in mental health” learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.
- **Payment** means activities such as obtaining payment for the mental health care services we provide for you either from your insurance or another third party payer. *For example* – we may include information with a bill to a third party payer that identifies you, your diagnosis, and procedures performed.
- **Health care operations** include the business aspects of running our practice. *For example* – to evaluate our treatment and services, or to evaluate our staff's performance while caring for you.

We may contact you to provide appointment reminders or other services that may be of interest to you. We will disclose your protected health information to any person *you identify* that is involved in your care or payment for your care. *For example* – a family member, relative, close friend, a pastor or pastor's representative whom you have asked us to communicate with.

We will use and disclose your protected health information *when required to by federal, state, or local law*. There are certain situations in which, as a therapist, I am required by ethical standards to reveal information obtained during therapy to other persons or agencies – even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required to use professional discretion regarding informing the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge or suspicion of physical, sexual, or emotional abuse or neglect of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare agency which may then investigate the matter; (c) if I am compelled by a court of law (court order) to turn over records to the court or are ordered to testify regarding those records; (d) prenatal exposure to uncontrolled substances; (e) professional misconduct by another healthcare professional must be reported.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke an authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate you understand our operational used of your information for treatment, payment, and healthcare operations as stated above.

Signature of Client/Responsible Party

Date