

Woodlands Family Institute, P.C.

Kristen N. Tripp, MA
Licensed Professional Counselor - Intern

Information, Policies, and Consent

I am very honored that you have chosen me to help you by providing counseling services. I will do everything I can to make this experience as meaningful and fruitful as possible. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I have a Bachelor's Degree in Psychology, and a Master's Degree in Clinical Mental Health Counseling. Additionally, I am an LPC-I supervised by Jennifer Cain, LPC-S, RPT-S. I hold a belief that no matter how difficult a person's circumstances may be, it is possible to produce meaningful changes. Sometimes this takes a long time to achieve. While some clients need only a few sessions to reach their goals, others may require months or even years. This is truly an individual quest. As a client, you are in complete control and may end our professional relationship at any point. I will be supportive of that decision. Ultimately, my job is to work myself out of a job, so that you feel confident to carry on without my intervention.

This process is a partnership between you and me to work on areas of dissatisfaction in your life or assist you with life goals. For this to be most effective, it is important that you take an active role in the process. This involves keeping scheduled appointments, being forthright about your issues and goals, and openly discussing the process with me. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. While counseling or psychotherapy can benefit most people, the process is not always helpful. Sessions can evoke strong emotions and sometimes influence unanticipated changes in one's behavior. It is important that you discuss with me any questions or discomfort you may have during the process. I may be able to help you understand the experience or use a different approach that may be more satisfying.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you arrange with me. It may be confusing and counter-productive for me to accept gifts or be invited to social gatherings. So please do not ask me to relate to you in any way other than in the professional context of our sessions. I want your sessions to be as safe and secure as possible so that we concentrate exclusively on your concerns. You are best served by experiencing me in my professional role. If at any time you are dissatisfied with my services, please let me know.

1610 Woodstead Court, Ste. 420, The Woodlands, TX 77380
Phone: 281-363-4220 Fax: 281-363-4010

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Children can be joyful and energetic, but with respect to the concerns which brought you to us, we request that you obtain a sitter for children not receiving treatment so that our full attention can be devoted to your priorities.

I assure you that our work will be conducted in a conscientious manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results for you.

Please be aware that I do *not* provide consultation, evaluation, or legal testimony in child custody, child visitation, or molestation cases. If you require these services, I will be happy to refer you to professionals who work with these issues.

Office Policies

1. Initial

Payment Policy: Payment is due in full at time of service. Please make out your check before the session begins. Visa, MasterCard and Discover are also accepted. It is not our policy to carry balances forward. We expect balances for “forgotten checkbooks” or “forgotten appointments” to be made up promptly or by the next regularly scheduled appointment at the latest. If an outstanding balance accrues, you will be billed on the first of the month and assessed a 2% finance charge, compounded monthly. There is a \$10.00 rebilling for every statement sent out after the first billing. There is also a \$15.00 fee for each check returned for insufficient funds. After 90 days with no payments or effort to arrange payment, accounts will be turned over to a collection agency and could impact your credit rating.

Session fee: \$125.00 (50 minute duration)

After hour’s session fee: \$225.00 per session.

Miscellaneous: Charges for other professional services are prorated on the basis of \$125.00 per hour, 15 minute increments. These services include, but are not limited to, phone calls, insurance reports, third-party consultations, and correspondence. Off-site consultation is prorated at the rate of \$125.00 per hour, “portal to portal”, that is, for the time I am out of the office on your behalf.

Legal testimony: Please be advised that I do not provide consultation, evaluation or legal expert testimony in child custody, child visitation or molestation cases. Similarly, I do not consider my practice to include expert testimonials.

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However, should my opinion be so ordered, fees will be charged at the rate of \$1,000.00 per hour, portal to portal. This fee will apply as well to depositions or interrogatories. Records review; consultation with clients, litigants, attorneys (in person or via phone or by email); reports; waiting at court; or any other service provided will be charged at the rate of \$250.00 per hour or prorated accordingly. These fees are **payable in advance**.

2. Initial

Office hours: Office hours are from 9 a.m. to 5 p.m. Monday, Tuesday, Thursday; 9 a.m. to 7 p.m. on Wednesday; and 9 a.m. to 4 p.m. on Friday unless otherwise specified. Any other time is considered "after hours" and will be charged at 1 1/2 times the standard rate. After hours' time is generally reserved for family time and self-care.

3. Initial

Cancellations: The scheduling of an appointment involves the reservation of time specifically for you. Therefore, 24 hours cancellation notice is required so that there will be no charge to your account. **PLEASE CALL THE OFFICE TO CANCEL AN APPOINTMENT. EMAIL IS NOT MONITORED FOR CANCELLATIONS.** If you are unable to meet this time schedule, but we are able to assign your appointment time to another client, you will not be charged. Due to the fact that your appointment is contracted time specifically set-aside for you, cancellations in advance will be appreciated. *Please note that insurance companies do not reimburse for missed appointments.*

4. Initial

Insurance: Your health insurance policy is a contract between you and your insurance company. I am not a party to that contract. Although I am not listed as a provider on any network panels, benefits are often available for services rendered by "out-of-network" providers. We advise that you contact a company representative to determine how your insurance company will reimburse you. If you elect to seek reimbursement by an insurance carrier for services rendered, we will provide you with a receipt to assist you in completing your insurance claim. We will consult your third-party payer only at your direction with such consultations billed to your account. Some insurance companies reimburse clients for services, and some do not. Those that do usually require a standard amount be paid by you before reimbursement is allowed, and then usually a percentage of the fee is reimbursable. The client remains responsible for payment in full, including any portion not reimbursed by insurance. **Please be aware that: Third-party payers require the provision of a diagnosis and supporting clinical data. We have no control over the confidentiality procedure of third parties once clinical information leaves this office. In all likelihood, a computer record will be generated.**

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Since I do not contract directly with insurance companies, I am responsible and accountable only to you. Thus my loyalties are not divided, and there is no conflict of interest.

The office staff is happy to provide you with insurance ready receipts for filing your claim. WFI does not file out-of-network insurance claims.

5. Initial

Confidentiality: The law protects the privacy of all communications between a client and psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by federal and state law. There are other situations that require only that you provide advanced written consent. Your signature on our *Acknowledgment* form provides consent for those activities, as follows:

You should be aware that we practice with other mental health professionals and utilize administrative staff. In most cases, some protected information must be shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. Occasionally, it is helpful to consult other health and mental health professionals about a client. During a consultation, every effort is made to avoid revealing a client's identity. Any other professionals consulted are also legally bound to keep the information confidential. These consultations are very commonplace and routine and may not ordinarily be mentioned in our sessions, unless it seems important to our work together. If you would prefer this to be handled differently, please let us know. All administrative staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

We also have contracts with some business services, such as an answering service, electronic claims processing service, and managed care organizations. As required by federal law, we have formal business associate contracts with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. Details of these contracts are available upon request.

I will keep confidential anything you say to me, with the following exceptions: a) you direct me to tell someone else; b) I determine that you are a danger to yourself or others; c) I am ordered by a court or regulatory body to disclose information; d) you disclose abuse or neglect of children, the elderly, or disabled persons; e) you disclose sexual mistreatment by another therapist; f) the need to

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release information to other professionals involved in your treatment; g) in proceedings in which a claim is made about one's physical, emotional, or mental condition; h) when disclosure is relevant in any suit affecting the parent-child relationship; i) where otherwise legally required. If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to other parties. **Again, please note: Third-party insurance companies require submission of diagnosis and specific clinical data. If you elect to use insurance or managed care to cover part of the cost of your sessions, please be aware that I may be required to provide that information.**

6. Initial

Emergency services: It is assumed that outpatient clients are self-responsible, autonomous, and not in need of day-to-day supervision. Outpatient clinicians cannot assume responsibilities for clients' day-to-day functioning, as can agencies or inpatient hospital settings. Nevertheless, in the event that an emergency occurs, leave a message with the answering service, making sure to state that your call is an emergency. We will respond to your call as promptly as possible. Routine calls will be returned during normal office hours. We can be reached at 281-363-4220 or 713-866-4494. If we are unable to respond quickly enough, please call 911 or your local emergency room.

Having read the policies described above, I agree to all professional policies, agree to meet all financial obligations, and agree that this contract replaces any earlier contracts. Additionally, I understand that there can be no absolute guarantee of cure in the practice of psychotherapy.

Signature(s)

Date

Client Information Statement

The Texas Boards of Examiners of Licensed Psychologists, Marriage and Family Therapists, Licensed Social Workers and Licensed Professional Counselors were established by the legislature to protect the public. In fulfilling its mission, the Boards enacted rules governing the practice of psychology, family therapy, and counseling. These rules require that a therapist provide prospective clients with sufficient information about the therapeutic process so that the client can make an informed decision whether or not to enter therapy.

Attached to this Information Statement is a general information statement, Agreement for Services and the information regarding the procedures or psychotherapy in general and our office policies.

After reading the agreements, please ask about any part of the agreement that you do not understand.

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PERSONAL DATA RECORD

Client Name _____ Date of Birth _____

Address _____

City/State/Zip _____

SSN _____ TXDL _____

Employer/School/Address _____

May we leave a message at any of the following?

Cell phone (circle one) _____ Yes No

Work phone (circle one) _____ Yes No

Unencrypted email address _____ Yes No

*** Please do not cancel appointments via email. You must contact the office directly.**

If you would like to use an address other than your home address for billing and other correspondence, please provide an alternative address below.

Other _____

CONSENT FOR TREATMENT

Client Name _____ Date of Birth _____

I give full consent for *myself, my child/adolescent or dependent* due to legal guardianship to receive outpatient mental health services until I notify WFI of any changes or until it is determined the treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for the individual stated above.

Authorized Signature

Date

REQUIRED: We require that a credit card be provided for after-hours appointments, missed sessions, and late cancellations. You may also designate the use of this card for regularly scheduled sessions.

Cardholder's Name _____ Relationship _____

MC/VISA/DISC No. _____ Exp. Date _____

Signature of Authorized User _____

Use for regular sessions, after hours, missed or late cancel sessions

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Financial Responsibility

Name of person(s) financially responsible for this account _____

Address/phone if different from client _____

Signature(s) _____

Relationship to client _____

Emergency Contact

Name _____ Phone _____

Alternate phone _____ Address _____

Relationship to client _____

Referred to our office by _____

May we send a **thank you** to the person who referred you? (circle one) Yes No

May we mention your **name** in that thank you? (circle one) Yes No

Appointment Reminders

As a courtesy, you will receive an appointment reminder to your email address or your cell phone (via text message or computer generated voice mail message), the day before your scheduled appointments.

Your name: (Please print): _____

Your email address: _____

Your cell number: _____

Where would you like to receive appointment reminders? (Check one or more)

_____ Via text message on my cell phone (normal text message rates will apply)

_____ Via email message to the address listed above

_____ Via automated voice mail message on my cell phone

****Missed appointment fees will still apply. 24 hour cancellation policy still applies. Please call the office if you need to cancel an appointment.****

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Signature

Date

{Please refer to pages 9-10 of this document}

I acknowledge that I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information and the Office Information and Office Policies**. I understand and accept those policies and practices. WFI is hereby granted consent to contact me as specified above and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

Client or Authorized Representative Signature

Date

_____ Refuse to Sign _____ Unable to Sign (specify reason) _____

Signature of Person Documenting Refusal or Inability to Sign

Date

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Woodlands Family Institute (WFI) may *use or disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *general consent*. 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 I consult with another health care provider, such as your family physician or a colleague.
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 my 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 WFI such as utilizing information that identifies you.
- “*Disclosure*” applies to activities outside of WFI, such as releasing, transferring, or providing access to information about you to other parties.

II. 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 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 psychotherapy notes. “*Psychotherapy notes*” are notes we have made about our conversation regarding a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy 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.

III. 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.
- **Abuse of the Elderly and Disabled:** 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 Department of Protective and Regulatory Services.
- **Sexual Misconduct by a therapist:** If you report to us any situation that constitutes sexual misconduct by a current or former therapist, then we are required to inform the licensing authority of the offending therapist.
- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information 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.

IV. Client's Rights and Our Professional Duties

Client's 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. (For example, you may not want a family member to know that you are seeking our services. Upon your request, we will send bills or other correspondence to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my 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 in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Our Professional Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a current copy in our offices. A current copy will always be available on our web site and you may request a personal copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Mary Piehl, Office Manager, or your therapist at (281) 363-4220.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Mary Piehl or your therapist at: 1610 Woodstead Ct., Suite 420, The Woodlands, TX 77380.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 3/28/2005. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in our lobby and on our web site. You may request a personal copy at any time.

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PSYCHOSOCIAL HISTORY

Date _____

Name of Patient _____

Date of birth _____

Presenting Problems:

- Recent life transition
- Depression, isolation, withdrawal
- Suicide gesture, attempt or ideation
- Homicidal ideation
- Self-abusive behavior
- Abuse (physical, emotional, sexual)
- History of traumatic life events (in addition to the previous)
- Neglect, abandonment
- Marginal to low IQ
- Difficulty at school or work
- Difficulty with authority
- Commits unlawful acts
- Under socialized (difficulty making friends)
- Anger outbursts/rage
- Runaway from home or placement
- Impulse control problems
- Low self-esteem
- Physically aggressive
- Destruction of property
- Sexual dysfunction
- Does not feel guilty about wrongdoing
- Paranoid thoughts, delusions
- Hallucinations (auditory, visual, tactile)
- Gender identity problems
- Excessive worry, racing thoughts, obsessions
- Compulsive behavior
- Substance abuse

Have you had any **treatment** for these problems before today? Y N

If yes, when? Where? Who was your doctor or therapist?

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History of psychiatric hospitalizations

Date _____ Location _____ Outcome _____

Date _____ Location _____ Outcome _____

Date _____ Location _____ Outcome _____

Family past psychiatric history

Family medical history

Personal past medical history

Drug and Alcohol Abuse

Any **family** history of drug and/or alcohol usage? Please list and describe _____

Any **personal** history of drug/alcohol usage? List and describe _____

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Family History (include spouse, significant other, children, parents, step families, adoption history, etc.)

Name	Relationship	Age	Living where?

Marital status of patient

Married _____ How long _____

Divorced _____ How long ago _____

Separated _____ How long ago _____

Widow/widower _____ How long ago _____

Other _____

Other significant adults or children in patient's life (Please include type of relationship-e.g. supportive, conflictual, etc.)

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Traumatizing Life Events

Have you experienced any history of significant abuse (physical, emotional or sexual)?

Please briefly describe _____

Any history of **significant life events** such as deaths, separation from parent(s), frequent moves, terminal illnesses in the family or close friendship?

Cultural Influences

With what ethnic/cultural groups do you personally identify? _____

With what ethnic/cultural group does your family most identify? _____

Describe any cultural values or beliefs that may impact treatment _____

Educational History

Highest degree earned _____

Current School attending _____ Grade _____

Average grade performance _____

Overall motivation to attend school _____

Extracurricular activities _____

Employment History

Present employment status-where-how long? _____

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Positive/negative aspects of current position _____

If on leave of absence or disability, will you return to present job? _____

Special interests/hobbies/skills

Additional Comments _____

Signature

Date

SUPERVISOR: Jennifer J. Cain, L.P.C.-S., R.P.T.-S. Counselor-Intern:

LPC-Intern Counseling Agreement

Please initial the following statements to acknowledge your understanding:

_____ I understand that [my child and/or] I am seeing a counseling intern for counseling services. This intern is earning hours toward counseling licensure.

_____ I understand the limits of confidentiality as explained by my counselor and have had the opportunity to ask questions about these limits.

_____ I understand that I may, at any time, request that my child and/or myself be seen by intern supervisor Jennifer Cain L.P.C.-S. for counseling services.

_____ I understand that the dynamics of my [and/or my child's] case will be discussed for staffing and educational requirements between the counseling intern and supervisor.

_____ I understand that counseling methods such as audiotape, videotape, or direct observation may be used during my [and/or my child's] sessions.

_____ I understand the supervisory relationship and the requirement for supervision do not otherwise affect my right to confidentiality, which will be maintained within the limits of the law.

_____ I understand that I am not required to sign this document.

Client's printed name Date

Signature of client or parent/guardian [if client is under 18 years of age]