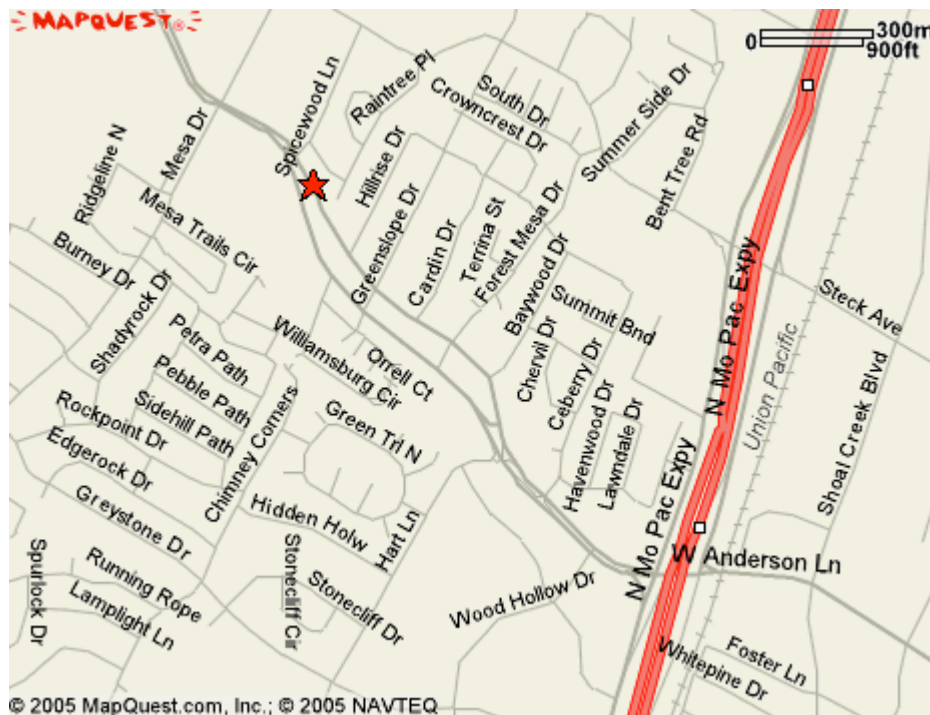


WELCOME

Those of us at Crossroads Counseling want to thank you for choosing to work with us and we want to make your time with us as productive as possible. In order to expedite the intake process, please complete the following forms before your first visit and bring them with you to your first appointment.

Our offices are located at 4131 Spicewood Springs Rd., Building K, Suite 1, on the south side of Spicewood Springs Rd between Mopac and Mesa Drive. Once you enter the Spicewood Forest Office Park take the first left and then the next left.

Payment will be expected at the time of service. Please remember our 24 hour cancellation notice.



INFORMED CONSENT

You are entering a therapist-client relationship with me, Dr John Haney, PhD., LPC.

The counseling relationship carries communication privileges and rights to confidentiality. I want to assure you that what you say and discuss in here will remain confidential. There are some situations, however, in which I am required by law and code of ethics to break confidentiality. Those situations include:

1. If you report a situation in which a child, elderly person, or anyone who cannot otherwise protect themselves is being neglected, or physically or sexually abused.
2. If you represent a harm to yourself.
3. If you represent a harm to someone else.
4. If my records are subpoenaed by the courts for purposes of litigation.
5. If you grant permission for your records to be sent to another Mental Health professional or some other kind of professional.

By signing this Informed Consent, you indicate that you recognize the limits of confidentiality. You understand that you have the right to terminate counseling at any time.

Fees:

Initial interview - \$150.00, thereafter \$135.00 per couple; \$125.00 for an individual.

Sessions are 50 minutes long and start on the hour.

If for any reasons you must miss a scheduled appointment you agree to call 24 hours prior to the appointment to cancel it or be responsible for paying the fee for the missed appointment.

If you are comfortable with the terms of confidentiality, please sign this form. I will keep it in your file, and if you wish, I will provide you with a copy for your records.

Client (or parent if for a minor) Signature: _____

Printed Name: _____

Counselor Signature: _____

Date: _____

Fee Information for John Mark Haney, PhD

FEES AND PAYMENT: Payment for services is expected at the time you check in for your appointment. If outpatient mental health services are covered under your medical policy, you may request a statement, which will permit you to file with your insurance provider for reimbursement.

PROFESSIONAL FEES

Diagnostic evaluation:	\$150
Individual session / 50 minutes	\$125
Marital or family session / 1 hour	\$135
All contact out side of normally scheduled sessions will be billed per hour (emergency phone time, court time, etc.)	\$300

CONFIDENTIALITY: All information received in therapy sessions is held in confidence, and may not be released to others without written consent. There are certain limits to confidentiality. These are: 1) if the client makes statements which lead the therapist to believe that the client may be a danger to self or others, then the therapist will notify appropriate authorities (e.g., Mental Health Deputies, police), and /or, in the case of a minor, the minor client's parent or guardian, in order that preventive action can be taken (additionally in the case of danger to others, the threatened individual(s) will be notified); 2) if the client reports child or elder physical or sexual abuse or neglect, the therapist is required by law to report this to the Department of Human services and / or the police; 3) if the client fails to pay for services, the right to confidentiality is limited to 60 days, after which the client's account may be turned over to a bill collector. The therapist will make efforts to fully discuss any circumstance which falls beyond the limits to confidentiality before disclosing the confidential information.

CANCELLATION POLICY: The appointment time has been reserved for you. In the event that you need to cancel, please call our office at least 24 hours prior to your scheduled appointment. Cancellations with less than 24 hours notice are subject to charges of the full fee. If you miss an appointment without canceling, you will be charged the full fee.

STATUS OF PRACTITIONERS: All treatment providers in this office are independent private practitioners, and as such are in no way responsible for the treatment provided to clients by one another.

I HAVE READ AND UNDERSTAND ALL PARTS OF THIS INFORMATION SHEET.

Name

Date

INTAKE QUESTIONNAIRE

MEDICAL INFORMATION:

Are you currently under the care of a physician or another mental professional? If so, name: _____, and for what condition? _____

Please state the reason for your visit: _____

Current Medications:

Prescriptions: _____

Non-Prescription: _____

Please list any other pertinent medical or mental health information: _____

Please read the following and check the appropriate responses:

	Yes	No
Have you seen a Therapist in the past?	_____	_____
Do you currently use alcohol?	_____	_____
Do you currently use any recreational drugs?	_____	_____
Is there a history of mental health problems in your family?	_____	_____
Have you ever been hospitalized for mental health reasons?	_____	_____
Is there a history of alcohol or drug problems in your family?	_____	_____
Any sexual, physical or emotional abuse?	_____	_____
Any history of suicide attempts?	_____	_____

RELIGIOUS AFFILIATION: (Please check the most applicable)

Protestant _____

Catholic _____

Jewish _____

Other _____ Please specify _____

Agnostic _____

Atheist _____

Are you currently a member of a church or synagogue? _____

SIGNATURE: _____ DATE: _____

PATIENT INFORMATION FORM

NAME _____ HM PHONE _____ WK PHONE _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS* _____ CELL PHONE _____

PREFERRED METHOD OF CONTACT? EMAIL _____ HOME _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

SPOUSE'S NAME _____ WK PHONE _____

CHILDREN (names and ages) _____

WHOM MAY WE CONTACT IN THE CASE OF AN EMERGENCY? _____

PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

PHONE _____

WHO IS FINANCIALLY RESPONSIBLE FOR OUR FEES? _____

ADDRESS OF RESPONSIBLE PARTY _____

I WILL BE PAYING TODAY BY CASH _____ CHECK _____ CREDIT CARD _____

I understand and agree that, (regardless of my insurance status); I am ultimately responsible for the payment of services rendered. I also understand that I will be responsible for the cost of all scheduled sessions unless they are canceled with 24 hours notice. Payment is due at the time of service I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge.

Signature

Date

* We will not send email unless you have checked the preferred to be contacted by email box.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW
PSYCHOLOGICAL AND HEALTH INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO IT,

PLEASE REVIEW IT CAREFULLY.
YOUR PRIVACY IS IMPORTANT TO US.

OUR COMMITMENT TO YOU AND YOUR PRIVACY

We understand that it is sometimes frightening to be asked to sign something that might seem only loosely understandable to you, and that is why we wanted to take a moment and explain the purpose of the new Federal HIPAA legislation and how it applies to you. HIPAA stands for the Health Insurance Portability and Accountability Act, and it was passed because of concerns about the handling of confidential health information in an age of electronic records and rapid information sharing. We want you to understand that we take your privacy very seriously, as well as our obligation to safeguard your protected health information (PHI). It is therefore very important to us that you understand our policies and legal requirements as well as your own rights and options. With this in mind, what follows is a description of our disclosure policies, an explanation of our duties to you, as well as an account of your rights under the law.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

We may use or disclose your protected health information (PHI), for treatment, payment, and health care purposes with your consent.

- **PHI:** Refers to information in your health record that could identify you.
- **Treatment:** We may use or disclose your health information to a physician or therapist providing treatment to you.
- **Payment:** We may use or disclose your health information to obtain payment for services we provide to you.
- **Health Care Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, business related matters such as audits and administrative services, case management and care coordination.
- **Use:** Refers to activities within our practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **Disclosure:** Refers to activities outside of our practice, such as releasing, transferring, or providing access to information about you to other parties.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your authorization is obtained. Authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we have requests for information for purposes outside of treatment, payment and health care operations, we will obtain authorization before releasing information. We also will obtain authorization before releasing psychotherapy notes. Psychotherapy notes are notes that we write during private, group, joint, or family counseling sessions. These notes have a greater legal protection than PHI.

As a client, you may revoke all authorizations (PHI and psychotherapy notes) at any time, provided that each revocation is in writing. You may not revoke authorization if the authorization has already been obtained and acted on or if 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, as required by law:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we are required to report it within 48 hours to the proper authorities.
- **Elderly or Disabled Person Abuse:** If we have cause to believe that an elderly or disabled person has been, or may be abused, neglected, or exploited, we are required to report it to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against us with the State Board of Examiners of Social Work, they have the authority to subpoena confidential mental health information that is relevant to the 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 I 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 physical injury by you to yourself or others, or that 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.

CLIENT'S RIGHTS AND THERAPISTS' DUTIES

Client's Rights:

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a requested restriction.
- 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 want to keep it confidential that you are seeing a therapist. Upon your written request, your bills may be sent to an alternative address).
- Right to Inspect and Copy: You have the right to inspect a copy of your PHI. Psychotherapy notes that are kept separate from PHI are protected.
- Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. The request may be denied, but the details of the amendment process will be discussed.
- 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. Upon request, details of the accounting process will be discussed.
- Right to a Paper Copy: You have the right to obtain a paper copy of this notice.

Therapist's 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 document after notification.
- If revisions to policies and procedures occur, you will be provided with such revisions at your next office visit.

QUESTIONS AND COMPLAINTS

If you have questions about this notice and your rights to privacy and your records, you may contact us at 512.346.9299. If you believe your privacy rights have been violated and wish to file a complaint, you may send your written complaint to Crossroads Counseling at 4131 Spicewood Springs Road, Building K, Suite 1, Austin, TX, 78759. 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 the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Please Print Name

Signature

Date

For Office Use Only

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

- Individual refused to sign
- Communication barriers prohibited obtaining an acknowledgement
- An emergency situation prevented us
- Other (please specify) _____

RELEASE OF CONFIDENTIALITY FOR COUPLE THERAPY

As a couple, we agree to engage in couple therapy that will include both joint and individual sessions. We understand our right to confidentiality in individual sessions and are willing to waive that right so that information shared in individual sessions may be shared during joint sessions.

We also understand that John Haney believes that couple therapy is most successful when the couple is willing to be completely open, not only with their therapist, but also with each other. For this reason, John Haney has explained that he encourages full disclosure of information between the partners.

Print Client Name_____

Client Signature_____

Date_____

Print Client Name_____

Client Signature_____

Date_____