Tom Bolls, MA, LPC
8500 North Mo-Pac #820
Austin, Texas 78759
(512) 468-7832

CLIENT CONTACT INFORMATION

Date _____

Client Name _____

Address _____

City _____ State _____ Zip _____

E-Mail Address _____

Home Phone _____ Okay To Leave Msg? _____

Cell Phone _____ Okay To Leave Msg? _____

Office Phone _____ Okay To Leave Msg? _____

Referral Source: How did you hear about me?

Please list any current medications that you are taking to manage your mood / stress:

Please list the name & number of the physician who prescribed these medications:

Please list the name(s) of other therapist that you have worked with (past or present)

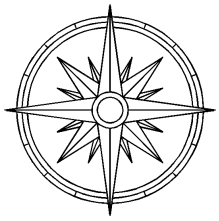
Name	Phone	Type of Therapy	Length of Time

Have you ever attempted suicide? _____

Have you ever been hospitalized for an emotional disturbance? _____

Have you ever been arrested for an altercation with another person? _____

Do you need a mandated assessment for a current court case? _____



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INFORMED CONSENT

I understand that counseling may involve discussing emotional issues that may at times be distressing. However, I understand that this process is intended to help me personally and in my relationships. I am aware that there are alternative treatment facilities available to me.

My therapist has satisfactorily answered all of my questions about counseling. If I have further questions, I understand that my therapist will either answer them or find answers for me. I understand that I may leave therapy at any time, although I have been informed that this is best accomplished in consultation with the therapist.

In signing this form, I understand that my role as a client is:

a. To be honest during counseling sessions, complete homework assignments and demonstrate a willingness to change.

b. To refrain from the use of alcohol or drugs the day of a counseling session.

Cancellation Policy

There is no charge for appointments cancelled with enough advance notice. Any client cancelling a session without (at least) 24 hours advance notice is responsible for paying the full fee of the missed appointment.

Payment Policy

All therapy sessions are 50-minutes in length (unless otherwise stated). Payment for services is expected at the end of the therapy session. I do not work with any type of insurance or managed care provider, but I will be happy to write you a receipt at the end of the month so that you can seek reimbursement on your own. Payments can be made in either cash or check.

STATEMENT OF UNDERSTANDING

I have read the statements above and agree to abide by them.

Client Signature:

Client Name:

Date:

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LIMITATIONS OF CLIENT / THERAPIST CONFIDENTIALITY

Confidentiality is of the utmost importance where the client / therapist relationship is concerned. It is essential for the safety of the therapeutic relationship that your communication with me is handled with the respect that it deserves. I will do my best to keep our conversations private; however, there are certain laws which supersede our confidentiality agreement.

Ethical Exceptions to Confidentiality Agreement

- A client threatens and has a plan for **suicide** (which usually requires hospitalization).
- A client reports **current abuse** of children, the elderly or the mentally challenged.
- A client reports **past abuse** of children, the elderly or the mentally challenged.
- A client reports there is a probability of imminent **harm to others**.
- A court of law **subpoenas** counseling records.

Federal Exceptions to Confidentiality Agreement

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations implemented standards for how information that identifies a patient can be used and disclosed. (Title 45, Code of Federal Regulations (CFR), Parts 160 and 164) The regulations apply to "covered entities" including health-care plans, health-care clearinghouses, and health-care providers. These privacy standards went into effect on April 14, 2003.

Section 164.512(d) permits covered entities to disclose private health information to a health oversight agency for oversight activities including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions, or other activities necessary for the oversight of the health-care system, government benefit programs, compliance with governmental regulation or compliance with civil rights laws.

STATEMENT OF UNDERSTANDING

I have read the preceding statement and understand that under the above-stated circumstances the confidentiality of the client-therapist relationship is superseded. I understand that in such instances my therapist is bound ethically and legally to inform the proper authorities.

Client Signature:

Date:

Client Name (Printed):
