

**KIM HUMPHRIES & ASSOCIATES**  
**CLIENT INFORMATION FORM**

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

City, State, Zip \_\_\_\_\_ Age \_\_\_\_\_

Contact information: Home ( ) \_\_\_\_\_ - \_\_\_\_\_ Work ( ) \_\_\_\_\_ - \_\_\_\_\_

Cell ( ) \_\_\_\_\_ - \_\_\_\_\_ \*Please note which is best contact number: Home \_\_ Work \_\_ Cell \_\_

\*Please indicate if we may leave a message. Yes \_\_\_\_ No \_\_\_\_

Email \_\_\_\_\_

\* Please note emails& texts are not encrypted. Therefore, we cannot guarantee confidentiality for these forms of communication.

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status: S \_\_\_\_ M \_\_\_\_ D \_\_\_\_ W \_\_\_\_ Sex: M \_\_\_\_ F \_\_\_\_

Children (and ages) \_\_\_\_\_

Any previous marriages \_\_\_\_\_ If yes, when? \_\_\_\_\_ How long? \_\_\_\_\_

Custody of children by former marriage? \_\_\_\_\_

Religious preference \_\_\_\_\_

**INSURANCE INFORMATION**

Name of Insured \_\_\_\_\_

DOB of Insured \_\_\_\_/\_\_\_\_/\_\_\_\_

Client Relationship to Insured \_\_\_\_\_

Place of Employment \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Insurance Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Policy/ID Number # \_\_\_\_\_ Group # \_\_\_\_\_

**Authorization to Release Information** \_\_\_\_\_ / \_\_\_\_/\_\_\_\_

(Without the above signature, insurance cannot be filed) (Signature) (Date)

Authorization to Pay Medical Benefits to Clinician \_\_\_\_\_ / \_\_\_\_/\_\_\_\_

(Signature) (Date)

## Client Payment Contract

The client and counselor decide upon an appointment time that is mutually agreeable. Please note that **payment is due at the time services are rendered.** Please also note that **you will be charged at the full billing rate for cancellations made less than 24 hours in advance.** Because insurance companies do not cover the cost of canceled sessions, you are responsible for the full payment of cancellation fees. If you need to reschedule, please do so by **calling 972-437-1400. Contacting by e-mail for cancellation will not insure 24 hours notice.** If you miss two appointments without notifying the office, the therapist reserves the right to terminate the therapeutic relationship. Although you are encouraged to telephone your counselor in an emergency, please be informed that you may be billed your regular rate for telephone calls in which you receive counseling. If for any reason the therapist is asked to appear in court on your behalf, it is understood that his/her time incurred for such court appearances will be your responsibility.

### Payment Procedures

**FEE INFORMATION:** The standard fee for services is \$180.00 per 45-50 minute session. Couples or family counseling is \$200.00 per session. Payment via Zelle or Venmo is preferred. Credit cards, Health Savings Accounts, and Flexible Spending Accounts are accepted but will be charged a \$5.00 processing fee. I have read and understood the above contract.

SIGNED: \_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_

### Philosophy of Counseling

The philosophy of counseling used in this office is based on the following principles. The first will be to maintain the highest clinical and ethical standards. Second, the approach to therapy seeks to maintain Biblical integrity. While recognizing the client's belief system may differ from the therapist's, there is a commitment to recommending principles compatible with the Christian faith.

\_\_\_\_\_ Date: \_\_\_\_\_

### Client consent

Form revised November 2016

How much influence does religion have in your daily living?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 7 \_\_\_\_\_ 8 \_\_\_\_\_ 9 \_\_\_\_\_ 10

Not at all Very Much

Referred by \_\_\_\_\_

Previous therapy? Y \_\_\_ N \_\_\_ Date \_\_\_\_\_ Therapist \_\_\_\_\_

Current Medication \_\_\_\_\_

Inpatient Y \_\_\_ N \_\_\_ Outpatient Y \_\_\_ N \_\_\_ Where \_\_\_\_\_

Personal Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Date of last exam \_\_\_\_\_

Please indicate if there is additional medical and/or personal information not previously requested that you feel should be included

**RECORDS AND CONFIDENTIALITY**

All communication is confidential, and your permission is necessary to release any information to outside persons except for the limitations required by the laws of the state of Texas. Exceptions to confidentiality may include (a) reasonable suspicion of incidents of child abuse or neglect, (b) incidents of elder abuse, (c) a determination that you are a danger to yourself or others, (d) a request from you in writing, directing the therapist to give a specified individual or agency information, or (e) the therapist is ordered by a court to disclose information.

Another exception would be in the event that your therapist is out of town or otherwise unavailable and another professional is providing emergency care for his/her clients; it is understood that this professional may need access to client files.

By signing below, you are indicating that you have read and understood this statement and that questions about this statement have been answered to your satisfaction.

Please note that emails and texts are NOT encrypted. Therefore, we cannot guarantee confidentiality for these forms of communication.

I acknowledge that I have received a copy of the HIPPA privacy rule forms.

\_\_\_\_\_  
Counselor's signature Date

\_\_\_\_\_  
Client's signature Date

\_\_\_\_\_ ( ) \_\_\_\_\_  
Client's emergency contact Contact's phone number

Use check marks to indicate which of the following areas are currently problems for you.

- Stress
- Worthlessness
- Hopelessness
- Feeling lonely
- Experiencing guilty feelings
- Suspicious feelings towards other people
- Afraid of being on your own
- Angry feelings
- Low self-esteem
- Feeling you don't belong
- Concerns about physical health
- Lack of self-confidence
- Feeling fat even though your weight is below average
- Eating and then vomiting to control weight
- Concerns about finances
- Feeling cut off from your emotions
- Difficulty expressing emotions
- Use of alcohol
- Use of non-prescription drugs
- Poor concentration
- Getting grades that are lower than you want
- Lacking assertiveness in some situations
- Difficulty being open with other people
- Difficulty communicating with boyfriend/girlfriend
- Difficulty communicating with spouse
- Difficulty making or keeping friends
- Isolation/social withdrawal
- Difficulty communicating with parents
- Feeling pressured by parents' expectations
- Feeling controlled/manipulated by parents
- Thoughts of taking your own life
- Thoughts of hurting yourself
- Thoughts of hurting others
- Difficulty living up to religious beliefs
- Difficulty making decisions
- Feeling guilty about sexual activities (past or current)
- Difficulties in sexual relations with spouse
- Disagreements with spouse concerning sex
- Feeling attracted to members of your own sex
- Physical abuse issues
- Sexual abuse issues
- Spousal abuse issues
- Low energy
- Anxiety/panic
- Grief and/or loss
- Delusions/hallucinations
- Phobias
- Obsessive/compulsive behaviors
- Sleep disturbance (circle one: more sleep or less sleep)
- Appetite disturbance (circle one: increased or decreased)

KIM HUMPHRIES, LCSW, ACSW, BCD  
KIM HUMPHRIES AND ASSOCIATES, LLC  
HEALTH INFORMATION RIGHTS

Although your records are the physical property of Kim Humphries and Associates, LLC the information belongs to you. You have the following rights with respect to your information, which you can exercise by presenting a written request to this office.

You have:

- The right to request restrictions on certain uses and disclosures of your information. However, we are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. For example – a request that we not identify the agency when we contact you. (i.e. “This is Kim Humphries and Associates calling.”)
  - The right to inspect and copy the information we maintain about you. However, we may deny an individual access, provided the individual is given the right to have such denials reviewed, in the following circumstances:
    - A health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.
    - The information makes reference to another person (unless the other person is a health care provider) and the health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person.
    - The request for access is made by the individual’s personal representative and the health care provider has determined, in the exercise of professional judgment, that the provision of access to such personal representatives is reasonably likely to cause substantial harm to the individual or another person.
  - If you wish to inspect or copy your information, you must submit your request in writing to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.
  - The right to billing records.
  - The right to revoke your consent to release information except to the extent that the agency has taken actions in reliance on the previously signed consent form.
  - The right to reasonable requests to receive confidential communications of protected health information from us by alternate means. For example, at your regularly scheduled appointment, by email, or by fax.
  - The right to amend your information if you feel it is incomplete or inaccurate. You must make this request in writing to your therapist stating exactly what information is incomplete or inaccurate and your reasoning to support your request. We will respond to your request within 60 days. In rare cases your request may be denied.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of this notice from us upon request.
  - The right to file a complaint if you believe we have violated your medical information privacy rights.
- You have the right to file a written complaint to Kim Humphries and Associates, LLC or directly to the Secretary of Health and Human Services.

To file a complaint with our practice you may contact the following licensing boards:

We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. If and when one is available, you may request a written copy of a revised notice from this office.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services Office of Civil Rights  
200 Independence Ave. S.W.  
Washington, D.C. 20201  
877.696.6775

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Signature of Client/Responsible Party

Date

**KIM HUMPHRIES & ASSOCIATES, LLC**

Texas Board of Social Work Examiners 1100 West 49th Street  
Austin, Texas 78756-3183  
(512) 719-3521

Form revised November 2019

**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 (HIPAA) 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 Kim Humphries and Associates, LLC and of your individual rights and Kim Humphries and Associates' 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 health care 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 learns 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, pastor, or pastor's representative with whom you have asked us to communicate.

We will use and disclose your protected health information when required 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 by ethical standards to inform the intended victim and/or appropriate law enforcement agencies;

(b) if you report to me your knowledge of physical or sexual abuse 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 or social agency which may then investigate the matter;

(c) if I am required by a court of law (court order) to turn over records to the court or if I am ordered to testify regarding those records.

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 use of your information for treatment, payment, and health care operations as stated above.

\_\_\_\_\_Signature of Client/Responsible Party    Date \_\_\_\_\_

**KIM HUMPHRIES & ASSOCIATES, LLC**

600 West Campbell Road, Suite One Richardson, TX 75080

Form revised November 2019