INTAKE INFORMATION FORM

Name _____Date of first Appointment ___/ ___/ ___

Date of Birth _____ Age _____ Gender: _____

Address_____ City_____ State_____

Zip Code_____ Email _____ Phone_____

Persons also residing in the home:

Name	Age	Gender	Relationship

By signing below, I give consent for the following:

_____Email communication including PHI information to this email address:

_____ I understand that email is not to be used for emergency situations including but not limited to suicidal thoughts or plans.

_____Telephone messages including PHI information to be left at this number_____.

_____I do not give consent for communication via email or leaving telephone messages.

Signed:_____Date_____

Name_____ Date_____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address: _____ Physician's Phone: _____

Name of Psychiatrist: _____

Psychiatrist's Address: _____ Psychiatrist's Phone: _____

Many managed care companies require that I have interaction with the client's physicians and/ or therapist to coordinate care. Do you give consent to discuss your care with the above named doctor and/ or therapist?

(Circle one) YES NO

Please sign here for either answer: _____

Date of last medical evaluation: _____ Date therapy session: _____

Current medications being taken:

1) _____ Dosage/ Freq _____ Start Date _____ Purpose _____

2) _____ Dosage/ Freq _____ Start Date _____ Purpose _____

3) _____ Dosage/ Freq _____ Start Date _____ Purpose _____

4) _____ Dosage/ Freq _____ Start Date _____ Purpose _____

Prescribed by: _____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason

Do you use recreational drugs? (Circle one) YES NO If no, have you used in the past ? (Circle one) YES NO

If yes, when did you stop? _____

Type of drug	Amount	How often

Do you drink alcohol? (Circle one) YES NO If no, did you drink previously? (Circle one) YES NO

Type of Alcohol	Amount	How often

Do you smoke cigarettes? (Circle one) YES NO Other forms of tobacco (Circle one) YES NO

Describe other medical history, chronic ailments, or other problems you experience: _____

_____

_____

Client Policy Information

Appointments

Your therapy time is reserved for you. Two appointments cancelled without 24-hour notification will result in your discharged from care. Obviously, unexpected illnesses and emergencies sometimes do occur.

Payment of Fees

Your session fee is _____. Payment is due at time of service.

Discharge Policy: Failure to show up for two consecutive appointments, no scheduled appointments for 30 days or behavior abusive in nature to any staff shall result in discharge from care.

Confidentiality

Although it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law: Confidentiality and exceptions to confidentiality are discussed below. In the event disclosures of your records or testimony is required by law you will be responsible for and shall pay the costs involved in producing the records and therapist's hourly rate for the time involved in giving testimony, travel, and reviewing records.

Discussions between a therapist and a client are confidential. No information is released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include, but are not limited to, the following situations: child abuse, abuse of the elderly or disabled, abuse of patients in mental health facilities, sexual exploitation, child custody case suits in which the mental health of a party is in issue, fee disputes between the therapist and the client, and in a negligence suit brought by the client against the therapist. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss the matter further. By signing the information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons giving you mental care services and payment for those services, and you are releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result. **By signing this information and consent form, you are further giving your consent to the undersigned therapist to contact any person the therapist deems reasonably necessary to protect me or a third party from harm including but not limited to the following person(s):**

_____ _____

Name Date

Emergencies

You may call 972-544-6633 to schedule an emergency session. If I am unavailable at the time of emergency and/or immediate treatment is needed, call 911, go to your local Emergency Room or the hospital covered by your insurance. If I should be out of town at any time, Telehealth services are an option. The name and number of another therapist will be available by request for you.

Frequency of Sessions: 1 x wk 2 x week 2 x month 1 x month PRN

Type of Therapy recommended _____

Initial goals of treatment, purpose, and techniques used:

1. _____

2._____

3. _____

I have read, understand, and agree to the policies and conditions of treatment listed above. Should I decide to not undertake treatment by Andrea Davis, I may contact any of the referrals she provides me or give notice that I decide not to participate in any treatment at this time.

_____ _____
Signature Date

_____ _____
Art Therapy Intern Date

_____ _____
Supervisor, Andrea Davis, LPC-AT/S, ATR-BC Date

RELEASE OF INFORMATION

Name of client_____

SS# _____

DOB _____

I, _____, authorize reciprocal disclosure

between _____ and

Name:_____Phone:_____

Of the following information for
_____ My personal records
_____ Photography of artwork made in art therapy
_____ Sharing with other healthcare providers as needed
_____ Continuity of care
_____ Other:
_____

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 that this consent shall expire 90 days after the date of patient discharge unless another date is specified.

Specification of the date, event, or condition upon which this consent expires:

_____Two months from Discharge from care_____

TO THE RECIPIENT: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

_____ _____
Parent/ Guardian Signature Date

_____ _____
Witness Date

INFORMATION AND CONSENT FORM

DALLAS ART THERAPY offers individual and group art therapy and counseling to children, adolescents and adults.

I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES and CLIENT POLICY INFORMATION and consent to the use of my Protected Health Information as set forth in the NOTICE OF PRIVACY PRACTICES AND CLIENT POLICY INFORMATION. _____ (please initial).

I understand that my payment will be $ _____ per session.

I understand that failure to cancel an appointment on two occasions, without a 24-hour notice shall result in a Discharge from care.

I understand that I have the right to make a complaint and receive a fair response from Andrea Davis, LPC-AT/S, ATR-BC , supervisor of _____in a reasonable amount of time. I am also aware that I can make a complaint about unethical or unprofessional behavior directly to Texas State Board of Examiners of Professional Counselors.

I have completely read and understand this information and have had an opportunity to ask for any clarification that I might need. I, therefore, give my informed consent for _____supervised by Andrea Davis, LPC-AT/S, ATR-BC, to treat me _____or my child_____.

Client's Signature _____ Date _____

Therapist's Signature _____ Date _____

Notice of Psychotherapist's 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.

l. Uses and Disclosures for Treatment, Payment and Health Care Operations:
DALLAS ART THERAPY may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions: "PHI" refers to information about your health record that could identify you.
"Treatment" is when your therapist provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when your therapist consults with another health care provider, such as your family physician or another therapist.
"Payment" is when Andrea Davis, LPC-AT/S, ATR-BC obtains reimbursement for your healthcare. Examples of payment are when your PHI is disclosed to your health insurer to obtain reimbursement for your health care or to determine eligibility of coverage
"Health Care Operations" are activities that relate to the performance and operation of a private 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 are coordination.
"Use" applies only to activities within the office, clinic, practice group, etc., such as sharing, employing, applying; utilizing, examining, and analyzing information that identifies you.
"Disclosure" applies to activities outside office, clinic, practice group, etc., such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosers Requiring Authorization:
Andrea Davis, LPC-AT/S, ATR-BC 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 a therapist is asked for information for purposes outside of treatment, payment and health care operations, an authorization will be obtained from you before releasing this information. An authorization will also be obtained before releasing psychotherapy notes. "Psychotherapy notes" are notes the therapist has mad about your conversation during a private, group, joint or family counseling session, which is kept separate from the rest of your medical record. 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) the therapist has 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. Use and Disclosures with Neither Consent or Authorization:

DALLAS ART THERAPY may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If the therapist has cause to believe that a child has been, or may be, abused, neglected, or sexually abused, they 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.
Adult and Domestic Abuse: If the therapist has cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, the therapist must immediately report such to the Department of Protective and Regulatory Service's.
Health Oversight:" If a complaint is filed against a therapist with the State Board of Examiners, 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 may be privileged under state and/or federal; thus, the therapist will not release information without written authorization from you or your personal or legally appointed representative or a court order. The privilege may not apply where 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 your therapist determines 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, your therapist may disclose relevant confidential mental health information to medical or law enforcement personnel.
Worker's Compensation: If you file a worker 's compensation claim, your therapist may disclose records relating to your diagnosis and treatment to your employer 's insurance carrier.

IV. Patients' Rights and Therapist Duties:

Patient's Rights:
Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosure of PHI about you. However, your therapist is 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 seeing a therapist. Upon your request, any bills can be sent to another location).
Right to Inspect and Copy -You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in the therapist's mental health and billing records used to make decisions about you for as long as the PHI is maintained the record. The therapist may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, your therapist 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. Your therapist may deny' your request. On your request, your therapist will discuss with you the details of the amendment process.
Right to an Accounting - You generally have the right to receive an accounting of disclosure of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, your · therapist 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 upon request, even if you have agreed to receive the notice electronically.

Therapist Duties:

Therapists are required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
Therapists reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes however, the therapist is required to abide by the terms currently in effect.
If the therapist revises its policies and procedures, you will be provided with a revised notice by mail.

V. Questions and Complaints:

If you have any questions about this notice, disagree with a decision your therapist makes about access to your records, or have other concerns about your privacy rights, you may contact your therapist.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The appropriate address will be provided upon request.

VI. Effective Date:

This notice goes into effect on the date you sign the Consent for Treatment Form and acknowledge receipt of this notice

Intake Notes Date_____

Lifeline
KFD
DAP
PHQ9