Confidential Client Intake Information Form

PLEASE FILL OUT ALL PAGES

Today's Date: ____________

Identifying Information:

Child's Name: ____
(last) (first) (middle)

Date of Birth: ______________________Age: _________ Gender: __________

City/State:____

Caregiver/Guardian Name: ____

Relationship: _________________________ Date of Birth: _________________________

Home Phone: _________________________ May we leave a message? ___ Y ___ N

Cell Phone: ___________________________ May we leave a message? ___ Y ___ N

Work Phone: __________________________ May we leave a message? ___ Y ___ N

E-mail: ____

Address (number and street): ____

City, State, Zip code: ____

Caregiver/Guardian Name: ____

Relationship: _________________________ Date of Birth: _________________________

Home Phone: _________________________ May we leave a message? ___ Y ___ N

Cell Phone: ___________________________ May we leave a message? ___ Y ___ N

Work Phone: __________________________ May we leave a message? ___ Y ___ N

E-mail: ____

Address (number and street): ____

City, State, Zip code: ____

Emergency Contact &: Relation: ____

Emergency Contact‘s Phone Number: ____

Primary Care Physician: ____

Referred By: ____

Presenting Problem:

What are you seeking help with today?

____

____

Presenting Problems (check all that apply):

___ Temper outbursts
___ Withdrawn
___ Daydreaming
___ Fearful
___ Clumsy
___ Overactive
___ Short attention span
___ Distractible
___ Peer conflict
___ Phobic
___ Other
___ Impulsive
___ Stubborn
___ Disobedient
___ Infantile
___ Mean to others
___ Destructive
___ Bedwetting
___ Self-mutilating
___ Head banging
___ Rocking
___ Shy
___ Strange behavior
___ Stealing
___ Lying
___ School trouble
___ Bowel/bladder control
___ Feeding/Eating issues
___ Sleeping problems
___ Drug/alcohol use
___ Sickly

Please explain other: ____

Medical History:

Has the child ever been hospitalized for illness, physical ailments, emotional problems, etc?

___ Y ___ N If yes, please explain where, when, and what for?

____

Has the child ever taken, or is he/she currently taking any medications? ___ Y ___ N

If yes, please list medication name and frequency of dosage ________________________

____

Does the child have any allergies that you are aware of (Le. latex, peanut, soy, etc.)?

____

Living Arrangements:

Number of moves in the child's life? _____ Ever placed, boarded, or lived away from family?

___ Y ___ N If yes, please explain ____

List all members of your household presently and indicate their relation to the parent:

____

____

____

Are you interested in counseling services for yourself or any of your family members? ___ Y ___ N

Developmental History:

Did the child's mother have any illness or complications before delivery? ___ Y ___ N

If yes, please explain.

____

____

Did the child's mother use alcohol or drugs during pregnancy? ___ Y ___ N

Length of pregnancy? __________ Full term? ___ Y ___ N Birth weight: _____ lbs. _____ oz.

Complications at birth? ___ Y ___ N if yes, please explain _________________________________

As far as you know, did your child meet developmental milestones at an appropriate age

(i.e. rolling, sitting up, babbling, and eating)? ___ Y ___ N

Educational History:

Name of school/daycare: ____

Types of classes: ___ Regular ___ Inclusion
___ ESE ___ EDB (Emotionally Disturbed Behavior)
___ Other (explain):

Does the child receive special services at school? ___ Y ___ N

If yes, which services and what is the frequency/duration of each?

Occupational Therapy ________ /week for _____ minute sessions

Physical Therapy ____________/week for _____ minute sessions

Speech Therapy _____________/week for _____ minute sessions

Counseling _________________/week for _____minute sessions

Social History:

Does the child attend extracurricular activities? ___ Y ___ N If so, describe: ____

____

in school, how many friends does the child have? ________________________

other pertinent comments in this regard: ____________________________

____

____ ____________________
Name of person completing information/relationship to child Date

RELEASE OF INFORMATION

You may consent for personal information contained within your clinical record to be disclosed to the persons and/or agencies identified below for the following reasons:

Planning and monitoring appropriate treatment.
Case review and consultation with your physician and/or health care providers.
Support and/or involvement of family members or significant other in treatment.

Your signature indicates that you authorize me to release/receive information from the parties named below. You may revoke this consent at any time by providing a written notice. Please refer to the HIPPA guidelines for additional privacy information.

Name of the person who referred you for services: ____

Address: ____

Phone: ____

Name of primary physician (if different from above): ______________________________________

Address: ____

Phone: ____

Any other parties that you authorize me to give/receive information regarding your treatment:

____

____

Family member(s)/significant other(s) who may participate in your therapy. Please indicate relationship to client.

____

____

Print client's name: ____ Date of birth: ____________

Client's signature: ____ Date: __________________

Parent/guardian signature: ___________________________________ Date: __________________

Witnessed by: ____ Date: __________________

STANDARDS AND POLICIES

I welcome you to counseling and look forward to working with you. I am honored that you have chosen to entrust me with this portion of your life's journey. This informational sheet provides you with my basic services and policies. Please read this information carefully, feel free to ask any questions that you have, initial each section and then sign the statement at the end.

QUALIFICATIONS **INITIAL _____**

I earned my Bachelors of Science degree from the University of Iowa in Biomedical Engineering, and an MBA in Business Administration from Pepperdine University. I received my Masters of Arts degree in in Professional Counseling from Texas State University. I am licensed as a Professional Counselor as well as a Marriage and Family Therapist. What this means is that l have completed all educational, testing and supervision requirements for practicing Counseling and Marriage and Family Therapists in the state of Texas.

SERVICES **INITIAL _____**

As a Licensed Professional Counselor and a Licensed Marriage and Family Therapist, I am equipped to help individuals, children, families, couples, and groups with a variety of disorders of an emotional, psychological, and spiritual nature. I employ a variety of educational and therapeutic techniques, specifically emotionally focused (feeling), behavioral (doing), and cognitive (thinking), to help you achieve your personal counseling goals. The counseling methodologies used will primarily come from cognitive "talk" therapy, solution-focused therapy, marital and family systems therapy, behavioral therapy, and experiential use of scripture. I am trained in Intimacy Therapy and am a Certified Anger Resolution Therapist. I often integrate spirituality and psychology, but will not impose my beliefs on my clients and am capable and willing to approach presented problems without the use of faith based interventions. I will gladly support you in finding a psychiatrist or medical professional if medication is needed.

OUR RELATIONSHIP **INITIAL _____**

My relationship with you is a confidential, professional relationship based on trust that is initially given, but ultimately earned from each client. In order to assist you in achieving your goals, I will be asking personal questions about you and your extended family's experiences and belief systems. While some clients only need a few sessions to achieve their goals, others require months and sometimes years of treatment. As a client, you have the freedom to end your treatment at any time, but I do ask that you participate in a termination session. Our sessions may be psychologically close, but the relationship is not social. Our contact will be limited to counseling sessions except in emergencies. You can leave me a confidential message and I will return your call as I am able.

RISKS AND BENEFITS **INITIAL _____**

Counseling is beneficial, but as with any treatment there are inherent risks. During counseling, you will have discussions about personal issues, which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. However, the benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal

relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals.

RECORDS AND CONFIDENTIALITY **INITIAL _____**

The session content and all materials relevant to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person(s). Limitations of such client held privilege of confidentiality exist and are itemized below.

1. If I have reasonable suspicion that a client threatens grave bodily harm or death to another person or threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious self bodily harm.
2. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
3. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
4. Suspected neglect of the parties named in items #3 and # 4.
5. If a court of law issues a legitimate subpoena for information stated on the subpoena.

In the case of couple or family therapy, material obtained from an adult client individually may be shared with the client's spouse or other family members only with the client's permission or when mandated or permitted by law. When working with couples, families, or groups, I cannot disclose any information outside of the treatment context without a written authorization from all individuals competent to sign such authorization. In the case of minor children (under the age of 18), the parents or managing conservator may legally request information concerning the child's progress and treatment. I will maintain confidentiality with minors and work with them to make disclosures to parents in a way that will preserve the therapeutic relationship.

Cellular Phones

I primarily use my cell phone to conduct business communication. By their very nature, cellular phone calls are not private. Occasionally, someone else may overhear a call. I will make every attempt to limit the use of my cellular phone in public places to insure your privacy to the best of my ability. Texting also creates privacy risks as they are posted as banner notifications and can be read. Texts become part of your clinical file and are subject to subpoena if records are requested so please limit content to scheduling needs. I will save your name in my phone contacts as your initials to limit identifying information but cannot guarantee confidentiality.

Social Media

I will not engage in social networking with clients on any social networking site such as Facebook, LinkedIn, Instagram, Twitter or any other social networking site as it is not professional and confidential to do so. Please do not send "friend" requests through any interactive or social networking websites, as I will not be able to accept them. By your signature below, you agree that you will abide by this stated professional boundary.

PUBLIC ACKNOWLEDGEMENT **INITIAL _____**

If I see you in a setting other than the office (public place, business or social setting) I will protect your confidentiality by not approaching you first. It will be your choice to either acknowledge knowing me or not. If you decide to initiate a greeting, I will respond. If you do not I will not signal verbally or non-verbally that we know each other, in order to maintain your confidentiality. Addition, I will not discuss your case in public. By your signature below, you indicate that you have been advised of this policy and you agree to abide by it.

LIMITATIONS OF COUNSELING **INITIAL _____**

I cannot offer a diagnosis for medical conditions, although I may recommend a medical or physical wellness exam to rule out possible physical issues/problems as a cause of any mental health symptoms. If you have a known medical condition, please let me know. With your permission, I will work closely with your physician to ensure the compatibility of treatment. I cannot prescribe medication. If it is determined that a medical evaluation is appropriate, I may refer you to a psychiatrist who can fully make a determination for medication as a necessary part of treatment. I will not make recommendations regarding custody, visitation or parental access to children or any matters pertaining to the ”best interest of the child” in Suits Affecting the Parent-Child Relationship (SAPCR), adoption or termination proceedings.

CONFIDENTIALITY ISSUES FOR MINORS **INITIAL _____**

As a therapist, I ask additional considerations on the part of the parents when a minor is the primary client. First, it is your responsibility as a parent to notify your therapist and anyone else so ordered if there is a court order influencing communication about counseling. Open communication among all parties, when possible, is the best philosophy. Secondly, I ask that parents respect their children’s privacy by allowing the therapist to take the lead on communicating relevant details from sessions. As a family—based model, I pursue treatment of familial relationships and will involve parents as soon as the therapist determines it is in your child’s best interest for parental involvement in the counseling work.

EMERGENCIES **INITIAL _____**

If you urgently require assistance, please call your physician, the Crisis Hotline (512-472-4357), or the police. While it is not possible to guarantee any specific results regarding your counseling goals, we will work diligently toward the results you desire.

TERMINATION **INITIAL _____**

Ideally, termination of the counseling relationship is mutually agreed upon by the client and counselor. My desire for my clients is that they be content with their direction in life or toward a solution, and relatively confident in their skills and abilities to accomplish it.

REFERRALS **INITIAL _____**

As a Licensed Professional Counselor and a Licensed Marriage and Family Therapist by the Texas

State Board of Examiners of Professional Counselors and the Texas State Board of Examiners of Marriage and Family Therapists, I adhere to the highest ethical standards and will keep your best interest at the forefront of all I do. If you are dissatisfied with my services at any time, please express your concerns. If I am not able to resolve your concerns, I will gladly provide you with a list of referral choices.

COMPLAINTS **INITIAL _____**

If you have a complaint regarding malpractice, this can be reported to the Texas State Board of Examiners of Professional Counselors, Complaints Management and Investigative Section, P.O. Box 141369, Austin, TX 78714-1369, at (512) 834-6658 or 1-800-942-5540 or the Texas State Board of Examiners of Marriage and Family Therapists, P.O. Box 149347, Austin, TX 78714-9347, at (512) 834-6657.

FEES **INITIAL _____**

Fees for counseling are due at the time service is rendered and are payable by cash, check or credit card. Please write your checks to: Chris Kingsbury Counseling Services. Fees per session for service are as follows: Individual $130 (50 minutes), Couple or Family $150 (50 minutes). In the case of a returned check, there is a $35 returned check fee. Phone consultations are charged on a prorated basis in 15 minute increments.

My fee for work legal-related work (i.e. attorney calls, writing reports, testimony preparation and court appearances) will be billed at $200.00/hr plus travel fees.

The fee for copies of client records is $20.00.

APPOINTMENTS AND CANCELLATIONS **INITIAL _____**

When you schedule an appointment, I reserve that time for you alone, so please make every effort to be on time to receive the full benefit of your allotted time. If you must cancel or reschedule your appointment I ask that you call my office at 512-948-9253 at least 24 hours in advance. This will free your appointment time for another client.

Cancellation Policy
If it is not an emergency and you do not provide 24-hours' notice, you will be charged for the appointment. If the appointment is longer than a 50 minute hour, you will be charged 50% of the total charge for the total time scheduled.

INSURANCE **INITIAL _____**

Full payment for your fee for services rendered is due at the time of your appointment. Medical insurance may often be applied to your professional counseling. I will provide you with a receipt that you may send to your insurance provider for reimbursement. I will also provide you with an appropriate diagnosis code to assist you in filing your claims.

HIPPA CONSENT FORM **INITIAL _____**

I have read and have been given a copy of Chris Kingsbury Counseling Services' "Notice of Policies & Practices to Protect the Privacy of your Health Information" (also known as "HIPPA Consent") form and understand that it describes how psychological and medical information about me may be used or disclosed and how I can gain access to this information.

CONSENT FOR TREATMENT

By my signature below, I am indicating that I have read, understand, and agree to the information contained in this agreement. I have read or have had satisfactorily explanations and I understand this disclosure of information, policies and client agreement. Any questions that I had about this statement including fees and payment policies have been answered and explained to my satisfaction (for client under the age of 18, consent must be given and this form must be signed by either a parent or legal guardian). I understand and agree to the description of confidentiality and the exceptions as stated above. I consent to counseling under the terms described above. My signature below indicates that I have received a copy of this form.

____ Date: ____________
Client's signature

____ Date: ____________
Client's signature

____ Date: ____________
Counselor's Printed Name

____ Date: ____________
Counselor's signature

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.

INTRODUCTION

Chris Kingsbury, LPC-S, LMFT-S is required by law to maintain the privacy of Protected Health Information ("PHI"), to provide individuals with notice of my legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and relates to the provision of health care or payment for the provision of health care for your past, present or future physical or mental health or condition and related healthcare services. This Notice of Privacy Practices ("Notice") describes how I may use and disclose PHI to carry out treatment, obtain payment or perform health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to PHI about you.

Chris Kingsbury, LPC-S, LMFT-S is required to follow the terms of this Notice currently in effect. I will not use or disclose PHI about you without your written authorization, except as described in this Notice. I reserve the right to change my practices and this Notice and to make the new Notice effective for all PHI I maintain. Upon request, I will provide any revised Notice to you.

MY PLEDGE

The privacy of your personal health information (PHI) is important to me. Your PHI includes, but is not limited to, medical, dental, pharmacy, and mental health information. This Notice describes my privacy practices. My privacy practices must be followed by all of my staff. This Notice tells you about the ways in which I may use and disclose your PHI. Also described are your rights and certain obligations I have regarding the use and disclosure of your PHI. I use and disclose your PHI in compliance with all applicable state and federal laws.

HOW PHI ABOUT YOU MAY BE USED AND DISCLOSED

The following categories describe different ways that I use and disclose PHI. For each category of use or disclosure, an explanation of what is meant and some examples are provided. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose PHI will fall within one of the categories.

For Treatment. I may use or disclose your health information to provide and coordinate the mental health treatment and services you receive. For example, if your mental health care needs to be coordinated with the medical care provided to you by another physician, I may disclose your health information to a physician or other healthcare provider.

For Payment. I may use and disclose your health information for various payment-related functions, so that I can bill for and obtain payment for the treatment and services I provide for you. For example, your PHI may be provided to an insurance company so that they will pay claims for your care.

For Healthcare Operations. I may use and disclose your health information for certain operational, administrative and quality assurance activities, in connection with my healthcare operations. These uses and disclosures are necessary to run the practice and to make sure that my clients receive quality treatment and

services. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

For Special Purposes. I am permitted under federal and applicable state law to use or disclose your PHI without your permission only when certain circumstances may arise. I am likely to use or disclose your PHI without your permission for the following purposes:

- **Individuals Involved in Your Care or Payment for Your Care**. I may disclose PHI to a close personal friend or family member who is involved in your medical care or payment for your care.

- **Disclosures to Parents or Legal Guardians.** If you are a minor, I may release your PHI to your parents or legal guardians when I am permitted or required under federal and applicable state law.

- **Worker's Compensation.** I may disclose your PHI to the extent authorized by and necessary to comply with laws relating to worker's compensation or similar programs established by law.

- **Public Health.** I may disclose your PHI to federal, state, or local authorities, or other entities charged with preventing or controlling disease, injury, or disability for public health activities.

- **Health oversight activities:** I may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, and inspections, as necessary for my licensure and for government monitoring of the health care system, government programs, and compliance with federal and applicable state law.

- **Law Enforcement.** I may disclose your PHI for law enforcement purposes as required by law or in response to a cyourt order, subpoena, warrant, summons, or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about a death resulting from criminal conduct; about crimes on the premises or against a member of my workforce; and in emergency circumstances, to report a crime, the location, victims, or the identity, description, or location of the perpetrator of a crime.

- **Judicial and administrative proceedings.** If you are involved in a lawsuit or a legal dispute, I may disclose your PHI in response to a cyourt or administrative order, subpoena, discovery request, or other lawful process.

- **United States Department of Health and Human Services**. Under federal law, I am required to disclose your PHI to the U.S. Department of Health and Human Services to determine if I am in compliance with federal laws and regulations regarding the privacy of health information.

- **Research.** Under certain circumstances, I may use or disclose your PHI for research purposes. However, before disclosing your PHI, the research project must be approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

- **Coroners, medical examiners, and funeral directors.** I may release your PHI to assist in identifying a deceased person or determine a cause of death.

- **Organ or tissue procurement organizations**. Consistent with applicable law, I may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

- **Notification.** I may use or disclose your PHI to assist in a disaster relief effort so that your family, personal representative, or friends may be notified about your condition, status, and location.

- **Correctional institution**. If you are or become an inmate of a correctional institution, I may disclose to the institution or its agents PHI necessary for your health and the health and safety of others.

- **To Avert a Serious Threat to Health or Safety.** I may use and disclose your PHI to appropriate authorities when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public. I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

- **Military and Veterans.** If you are a member of the armed forces, I may release your PHI as required by military command authorities. I may also release PHI about foreign military personnel to the appropriate military authority.

- **National Security, Intelligence Activities and Protective Services for the President and Others.** I may disclose your PHI to authorized federal officials for intelligence, counterintelligence, provision of protection to the President, other authorized persons or foreign heads of state, and other national security activities authorized by law.

- **As required by law.** I must disclose your PHI when required to do so by applicable federal or state law.

- **Treatment Alternatives**. I may use and disclose PHI to tell you about or recommend possible alternative treatments, therapies, health care providers, or settings of care that may be of interest to you.

- **Health-Related Benefits and Services**. I may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you.

- **Appointment Reminders.** I may use or disclose PHI to provide you with appointment reminders (such as textl messages, postcards, or letters). You have a right, as explained below, to request restrictions or limitations on the PHI I disclose. You also have a right, as explained below, to request that information be communicated with you in a certain way or at a certain location.

Other Uses and Disclosures of PHI

Your Authorization. I will obtain your written authorization before using or disclosing your PHI for purposes other than those described above (or as otherwise permitted or required by law). If you give us an authorization, you may revoke it by submitting a written notice to my Privacy Officer at the address listed below. Your revocation will become effective upon my receipt of your written notice. If you revoke your authorization, I will no longer use or disclose health information about you for the reasons covered by the written authorization. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, I cannot use or disclose your health information for any reason except those described in this Notice.

Psychotherapy Notes. I will not use or disclose psychotherapy notes without your written authorization, and only as permitted by law.

Marketing Health-Related Services. I will not use or disclose your protected health information for marketing communications without your written authorization, and only as permitted by law.

Sale of PHI. I will not sell your protected health information without your written authorization, and only as permitted by law.

CHANGES TO THIS NOTICE

I reserve the right to change my privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changed Notice effective for all health information that I maintain, including health information I created or received before I made the changes. When I make a change in my privacy practices, I will change this Notice and make the new Notice available to you.

YOUR HEALTH INFORMATION PRIVACY RIGHTS

You have privacy rights under federal and state laws that protect your health information. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think that your rights are being denied or your health information isn't being protected. Providers and health insurers who are required to follow federal and state privacy laws must comply with the following rights:

To Request Restrictions on Certain Uses and Disclosures of PHI. You have the right to request restrictions on my use or disclosure of your PHI by sending a written request to the Privacy Office. I are not required to agree to those restrictions. I cannot agree to restrictions on uses or disclosures that are legally required, or which are necessary to administer my business. I must agree to the request to restrict disclosure of PHI to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the PHI pertains solely to a health care item or service for which you, or another individual other than a health plan on behalf of you, has paid us in full.

To Request Confidential Communications. You have the right to request that PHI be communicated to you by alternative means or at alternative locations. For example, you can ask that you only be contacted at work or by mail. I will accommodate all reasonable requests.

To Access PHI. You have the right of access to inspect and obtain a copy of your PHI. You may not be able to obtain all of your information in a few special cases. For example, if your treatment provider determines that the information may endanger you or someone else. In most cases, your copies must be given to you within thirty (30) days, but may be extended for another thirty (days) if you are given a reason by us in writing. I may charge you a fee for the costs of copying, mailing and supplies that are necessary to fulfill your request.

In accordance with Texas law, you have the right to obtain a copy of your PHI in electronic form for records that I maintain using an Electronic Health Records (EHR) system capable of fulfilling the request. Where applicable, I must provide those records to you or your legally authorized representative in electronic form within fifteen (15) days of receipt of your written request and a valid authorization for electronic disclosure of PHI. You may request a copy of an authorization from the Privacy Office at the address below.

To Obtain a Paper Copy of the Notice Upon Request. You may request a copy of my current Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy. You may obtain a paper copy from the Privacy Office at the address below. A reasonable fee may be charged for the costs of copying, mailing or other supplies associated with your request.

To Request an Amendment of PHI. If you feel that PHI I have about you is incorrect or incomplete, you may request an amendment to the information. Requests must identify: (i) which information you seek to amend, (ii) what corrections you would like to make, and (iii) why the information needs to be amended. I will respond to your request in writing within 60 days (with a possible 30-day extension). In my response, I will either: (i) agree to make the amendment, or (ii) inform you of my denial, explain my reason, and outline appeal procedures. If

denied, you have the right to file a statement of disagreement with the decision. I will provide a rebuttal to your statement and maintain appropriate records of your disagreement and my rebuttal.

To Receive an Accounting of Disclosures. You have the right to request an accounting of your PHI disclosures for purposes other than treatment, payment or healthcare operations. Your request must state a time period. The time period for the accounting of disclosures must be limited to less than 6 years from the date of the request. I will respond in writing within 60 days of receipt of your request (with a possible 30-day extension). I will provide an accounting per 12-month period free of charge, but you may be charged for the cost of any subsequent accountings. I will notify you in advance of the cost involved, and you may choose to withdraw or modify your request at that time.

To Notification in the Event of a Breach. You have a right to be notified of an impermissible use or disclosure that compromises the security or privacy of your PHI.
I will provide notice to you as soon as is reasonably possible and no later than sixty (60) calendar days after discovery of the breach and in accordance with federal and state law.

To File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with my privacy officer, listed below. You may also file a complaint directly with any or all of the following federal and state agencies: the Secretary of the Department of Health and Human Services, the Office of the Attorney General of Texas, or the applicable Board of the Texas Department of Health and Human Services: Texas State Board of Examiners of Professional Counselors, Texas State Board of Examiners of Marriage and Family Therapists or Texas State Board of Social Worker Examiners. I will provide you with the addresses to file your complaint with the Secretary, the Office of the Attorney General of Texas and the or the applicable Board of the Texas Department of Health and Human Services: Texas State Board of Examiners of Professional Counselors, Texas State Board of Examiners of Marriage and Family Therapists or Texas State Board of Social Worker Examiners, upon request. You will not be penalized in any way for filing a complaint.

If you want more information about my privacy practices or have questions or concerns, please contact me at:

Chris Kingsbury, MA, LPC-S, LMFT-S, NCC, DCC
201 S. Lakeline Blvd Cedar Park, TX 78613
512- 948-9253

By your signature below, you are indicating that you have read, understand, and agree to the information contained in this HIPPA agreement. Any questions you may have concerning this agreement have been answered to your satisfaction.

____ Date: _____________
Client's signature

____ Date: _____________
Client's signature

____ Date: _____________
Counselor's Printed Name

____ Date: _____________
Counselor's signature