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# Client Information

Client Legal Name: _____ Preferred Name: _____

Date of Birth: _____ / _____ / _____ Age: _____ Gender: M ☐ F ☐

Home Address: _____
(Street) (Apartment #)

_____
(City) (State) (Zip code)

Phone: Home: _____ Work: _____ Cell: _____
*if minor, parent or legal guardian's contact phone and email

Email: _____

Employment Status: ☐ Employed ☐ Student ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Other

Who is financially responsible for services provided?: _____

**How would you like appointment reminders sent to you? (Select one):**

☐ Phone call (check one): ☐ Home ☐ Work ☐ Cell

☐ Email (Please provide email if different from above): _____

☐ Text message

Please Note: Automated reminders are a courtesy. It is the client's responsibility to manage appointment dates and times.

**Emergency Contact Information:**

Name: _____ Relationship: _____ Ph: _____

Name: _____ Relationship: _____ Ph: _____

**How did you hear about us?**

☐ Friend ☐ Doctor ☐ Insurance ☐ Other: _____

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# Additional Information for Child/Adolescent

Child / Adolescent's Name: _____

School: _____ Teacher: _____ Phone: _____

Custodial Parents: _____

Phone: Home: _____ Work: _____ Cell: _____

**If Divorced*:** Non-Custodial Parents: _____

Phone: Home: _____ Work: _____ Cell: _____

Year Divorced: _____ Age of Child at Divorce: _____

** In cases of divorce, Texas State Law requires a copy of the full divorce decree to be part of a minors medical and mental health records.*

Please list all siblings:

_____ Age: _____ Gender: ☐ M ☐ F

_____ Age: _____ Gender: ☐ M ☐ F

_____ Age: _____ Gender: ☐ M ☐ F

Reason for seeking therapy: _____

_____

## Guardian's Consent for Treatment

I acknowledge that I, _____ , am the legal guardian of _____.
I hereby give my consent for him/her to receive counseling services at Lifeworks Counseling Center. Treatment may include any of the following: Play Therapy, Individual Therapy and/or Family Therapy. I realize that the nature and content of such services must remain confidential unless limitations of confidentiality are mandated otherwise.

Signature of Parent or Guardian: _____ Date _____

If you do not have Adobe to create a digital signature, please initial for approval: _____


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# Credit Card Authorization

Lifeworks requires a credit card on file to use when there is a late cancellation or no show for appointments as well as any balances over 60 days. **These fees cannot be paid with an HSA card and are not reimbursable by insurance.**

To cancel an appointment please call 972-466-2800. If you do not reach the office staff, leave a detailed message. All messages are date and time-stamped. Missed appointments and late cancellations are assessed $75 unless the office is able to fill the time slot. In the event of illness, you must provide a doctor's note at your next scheduled appointment to avoid the late cancellation fee.

I, the undersigned individual, authorize Lifeworks Counseling Center to charge my credit card in the event that I (or the party for whom I am financially responsible} fail(s) to show for a scheduled appointment, or do/does not notify Lifeworks at least 24 hours in advance of a canceled appointment. Furthermore, for any outstanding balance that remains unpaid for 60 days after services rendered, I authorize Lifeworks to charge my credit card for the full amount due. I agree to not dispute charges for any of these reasons. I further authorize Lifeworks to disclose information about my attendance and/or cancellation to my credit card company if I dispute a charge. I understand that this authorization will remain in place until termination of treatment which must be done via a termination session, phone call or in writing. I understand my card will be charged even if I terminate treatment if a balance remains.

Card Type {please check one): ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card #: _____

Expiration Date: _____ /_____ Security Code: _____

Name (as printed on card): _____

Name of client if credit card holder is not the client: _____

Billing Address: _____ Zip: _____

☐ **Same as home address**

Signature: _____ Date: _____

(Client or financially responsible party)

**if you do not have Adobe to create a digital signature, please initial for approval: _____**

*****If you prefer not to provide a credit card on file, you must provide a $75 deposit at your first visit to be held to cover above fees. If a late cancellation or no-show fee has been charged to your account, you must replenish this deposit at your next visit. This deposit will be refunded to you at the termination of your treatment provided no balance is due.**

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# Group & Private Health Insurance

## Assignment and Instruction for Direct Payment to Provider

Client's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Company Name or Mental Health Network: _____

Phone Number from Insurance Card: _____
*(Note: Your card may have a separate phone number for mental health/substance abuse.)*

Member Identification Number: _____Group Number: _____

Insured Name (Last, First, MI): _____

Insured's Address: _____

Insured's Phone: _____ Insured's DOB: _____

Insured's Gender: ☐ Male ☐ Female. Insured's Employer: _____

I hereby instruct and direct the insurance company named above to pay by check made payable to: Lifeworks Counseling Center, PLLC, 2625 N. Josey Lane, Suite 250, Carrollton, TX 75007; the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS FROM THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assigned, and I agree to pay any balance of said professional services charges over and above this insurance payment at the time service is rendered.

I also authorize the release of any information pertinent to my case to any insurance company. A photocopy or facsimile of this Assignment shall be considered as effective and valid as the original.

Signature of Client or Policyholder: _____ Date: _____

If you do not have Adobe to create a digital signature, please print your name for approval: _____

# Client Agreement/Informed Consent

## Overview:

Lifeworks Counseling Center (LWCC) is an independent agency and has no relationship with any managed care or insurance company. We do not accept third party reimbursement. Our psychotherapy services are offered to individual adults, couples, families, and children. We also periodically offer group psychotherapy for a variety of different issues.

## Therapist Orientation and Credentials:

There are many different approaches to the therapeutic process. Your therapist will work with you to provide you with the most appropriate interventions for your particular issue(s)/goals. Please discuss any concerns or questions you have regarding your treatment with your therapist at any time during the process.

## Services Offered:

The following is a brief description of LWCC's philosophy of the services we provide:

### Psychotherapy:

Psychotherapy in its broadest definition is about growth. It is about living more authentically and autonomously by removing defenses and other "survival" responses that were developed during one's life, most often in childhood. One goal of therapy is to replace these dysfunctional patterns with responses that are more congruent with the individual's present life and social environment. During the initial stages of therapy an understanding of the process and a beginning awareness of the underlying issues take place.

During the intermediate stages of psychotherapy, awareness and understanding progresses to a more active status, in which old dysfunctional patterns begin to be replaced with more appropriate, and healthier responses.

In the final stages of therapy, a client becomes increasingly able to continue the growth process on his/her own. The safety and support of the therapeutic relationship has been replaced with an internal autonomy and authenticity, allowing the individual to face his/her own issues, and adjust the psychological course as necessary and desired.

### Testing/Assessment (when services are available):

Psychological assessment provides the opportunity to evaluate an individual compared against normative samples in order to determine how similar or different they are from the normative group.
Psychological assessment typically presents a relatively low risk to participants. It is possible that individuals may feel uncomfortable or anxious about being tested. Assessors are trained to detect and respond sensitively to indications of anxiety.

The benefits of completing a psychological assessment may include obtaining a detailed description of strengths and challenges in the areas covered by the assessment (e.g., intellectual, academic, social-emotional functioning), and recommendations for addressing areas of difficulty. For example, this information might be useful to help an individual qualify for special accommodations in his or her educational or work environment.

## Confidentiality:

Texas state law requires that information provided to mental health practitioners remain confidential, and LWCC makes every effort to ensure confidentiality is maintained with respect to all aspects of your treatment. Please be aware that there are limitations and exceptions to confidentiality, in which case information may be disclosed to the appropriate authorities/agencies/individuals. This includes:

- If your therapist has reason to believe that you are in imminent harm to yourself or others. (This may include appropriate measures to prevent self-harm and/or request for emergency assistance or transportation to the appropriate facility.)
- If your therapist has reason to believe that you are involved in or have knowledge of abuse or neglect of a child, elderly, or disabled person.
- Ordered disclosure by state or federal courts.


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Confidentiality (cont'd)

**Additionally,** LWCC will release information with your signed consent in the following circumstances:
- Granting permission to designated third parties to receive information (as needed).
- Discussion of the case with your therapist's clinical supervisor (if applicable).

## Confidentiality With Regard To Minors:

**The parents or legal guardians of LWCC clients under the age of 18 have the right to access their child's psychological records. The exception to this is in the case of an emancipated minor. A minor is emancipated if he or she is on active duty with the armed services, is married, or is 16 years of age or older and resides separate and apart from his/her parents, managing conservator, or guardian and manages his/her own financial affairs. Your child's therapist will discuss with you the limitations, procedures, and implications with regard to your child's records and progress.**

## Appointment Scheduling/Attendance:

Regular psychotherapy promotes faster healing and progress, so it is important that you attend your scheduled therapy session consistently. The time and day of your appointment should be coordinated with our office staff. After your first session, if you would like to schedule your appointment via the Internet, you will get information on how to schedule appointments through our online service called Therapy Appointment.

Courtesy reminders are available by phone call, text or email. **Please note: Regardless of any reminder you request, you are accountable for your appointment time and any associated fees for missing an appointment.**

## Late Cancellations and No Shows:

- If you cannot attend a session, you agree to notify our office at least 24 hours in advance.
- You understand there will be a charge of $75 for **any** session cancelled with less than a 24 hour notice AND **any** appointment that you miss. In the event of illness, you must provide a doctor's note at your next scheduled appointment to waive the late cancel fee, otherwise fee will incur. ***Please note:*** Missed appointments CANNOT be filed with insurance.
- Lifeworks requires a credit card on file to use when there is a late cancellation or no show for appointments as well as any balances over 60 days. If you have an HSA card on file, you will need to provide a different credit card for these fees.
- If your therapist is involved in an emergency, our office will contact you to make future arrangements.

## Length and number of sessions:

Sessions typically last 45-60 minutes. They begin promptly and end at the scheduled time. If you arrive late, which sometimes can occur, please note that the session will not be extended beyond the regularly scheduled time. The total number of sessions is dependent on a number of factors including your goals, timeframe, rate of progress, etc. Psychotherapy resulting in lasting change can sometimes be a long-term process, lasting several months or longer. Please discuss any issues/concerns you have with your therapist so that an appropriate treatment plan can be formulated which will best suit your needs/desires.

## Fees/Payment:

LWCC office visit fees vary by therapist and licensure. Initial session rates are $150-$200, following session rates are $150-$155. Our therapists are providers for most insurance panels and you are responsible for your deductible and copay.

Our office staff will review your benefits with you.
- Payment is due at the time of service.
- By law LWCC is not allowed to waive deductibles or copayments.
- There is a $30.00 service charge for each check that is returned to LWCC.
- If after 60 days your account is not paid, LWCC may assign your account to an outside collection agency.
- Fees for any requests of therapists to appear in court are $250/hour, a minimum of eight (8) hours a day, paid in full prior to date of appearance, regardless of provided testimony.

## Risks of Counseling:

While positive benefits are expected from counseling services, specific results are not guaranteed. The work you will do involves personal exploration and may lead to major changes in your perspective and life decisions. Some of these changes could be temporarily distressing. However, please know that your therapist will work towards the best possible results for you.

Some of the more common risk factors that you should be aware of are:

- Deterioration in emotional and psychological stability at different times during the therapeutic process. This often
- occurs during the beginning stages of therapy, but may occur at any point, often brought on by an awareness of
- previously unconscious, emotionally-laden material.
- Significant relationships may experience varying degrees of tension as a result of the therapeutic change. This is
- most prevalent within family relationships but may extend beyond into one's social and professional life.
- Long-lasting psychological change often requires a significant investment of time, often longer than a client's initial
- perception.
- It is important to remember that if you choose to utilize your insurance, LWCC will be obligated to provide them certain information about your case including (but not necessarily limited to) diagnosis, type and dates of service. By assigning benefits to LWCC you are authorizing us to provide your insurance carrier (or their intermediary) with whatever information is necessary to process the claim. If you choose to utilize your insurance, it may affect your insurability. If at any time you have questions about the fees or insurance, please feel free to discuss them with us.

## Therapeutic Relationship:

The relationship between therapist and client is the impetus through which client change takes place. As such, it is often one in which close emotional bonds develop. It is also a professional relationship in which appropriate boundaries must be maintained. For the most part, the therapeutic relationship begins and ends at the therapy office. Although this is sometimes difficult to understand, it is an ethical requirement for maintenance of the therapeutic environment. As such, your therapist cannot be expected to be involved in a social relationship or friendship of any kind that exists outside of the therapy room. Also, LWCC's therapists value your right to privacy. Included in this value is our pledge to acknowledge you in public only if you first approach the therapist.

## Right to Withdraw from Treatment:

If a conflict arises for you or your therapist, either has the right to withdraw from the treatment process. If your therapist feels the need to withdraw from providing treatment, he/she will inform you and provide appropriate referrals.

## Record storage/interruption of services:

If an unforeseen event occurs which renders your therapist unable to continue to provide services (illness, death, etc.) or if your therapist retires, LWCC will provide you with information on obtaining your records should you need a referral. In the event of sudden illness or unforeseen event, a member of our therapy staff will be available to provide services in the interim until your therapist is able to return to work or until a referral is made.

## Grievance/Complaint:

You have the right to file a confidential grievance if you have an unresolved concern regarding your counseling services, or any issue involving any representative of LWCC. Any grievance should be in written form and addressed to:

Wayne M. Cagle, MEd, LPC-S/Owner
LifeWorks Counseling Center
2625 N. Josey Ln., Suite 250
Carrollton, Texas 75007

For complaints involving post-graduate and licensed therapists, you may also contact the appropriate licensing board listed below:

- Texas State Board of Examiners of Professional Counselors (512) 834-6658; 1100 West 49th Street, Austin, TX 78756
- Texas State Board of Examiners of Marriage & Family Therapists (512) 834-6657; 1100 West 49th Street, Austin, TX 78756
- Texas State Board of Examiners of Psychologists (512) 305-7700; 333 Guadalupe, Ste. 2-450, Austin, TX 78701

## After Hours Policy/Emergencies

If you need to contact your therapist you may do so by leaving a message with the staff at LWCC and it will be forwarded to your therapist. ***In an emergency situation, please call the Suicide and Crisis Center any time at 214-828-1000, or the 24-hour crisis hotline at 214-330-7722 or 911.*** LWCC is not a crisis facility and will not be held responsible for any damages occurring as a result of unmet crisis or acute care needs. Non-emergency phone calls will be returned the following business day.

## YOUR PRIVACY RIGHTS

You have the following rights regarding health information we maintain about you:

### Right to inspect and copy

You have the right to inspect and copy your health information, such as progress notes and billing records. You must submit a written request and a copy of your driver's license to LWCC in order to inspect and/or copy your information. If you request a copy of the information, a fee of $50 will be charged for the costs of copying, mailing or other associated supplies. Your therapist may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your information, you may ask that the denial be reviewed. If such a review is required by law, the Custodian of Records of LWCC will review your request and therapist's denial.

### Right to amend

If you believe the information we have about you is incorrect or incomplete, you may ask your therapist to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Record Amendment/Correction form to your therapist. Your therapist may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, your therapist may deny your request if you ask him/her to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment
b) Is not part of the information that we keep
c) You would not be permitted to inspect and copy
d) Is accurate and complete

### Right to an accounting of disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of confidential information about you. To obtain this list, you must submit your request in writing to your therapist. It must state a time period, which may not be longer than seven years. Your request should indicate in what form you want the list (for example, on paper, electronically). A fee of $50 will be charged to you for the costs of providing the list. Your therapist
will remind you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. LWCC has 15 days to reply to your request.

### Right to request restrictions

You have the right to request a restriction or limitation on the confidential information we use or disclose about you for any of the purposes outlined above. You also have the right to request a limit on the information we disclose about you. We are not required to agree to such requests.

### Right to request confidential communications

You have the right to request that we communicate with you about treatment matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests.

*Your Privacy Rights (cont'd)*

Right to a paper copy of this notice

You have the right to a paper copy of this notice. You may ask your therapist or our office staff to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, inform our office staff.

## Changes to This Notice

We reserve the right to change this notice, and to make the revised or changed notice effective for confidential information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right-hand corner. You are entitled to a copy of the notice currently in effect.

## How to Use Your Rights Under This Notice

*Complaints and communications to us*

If you wish to communicate with us about privacy issues or if you believe your privacy rights have been violated and wish to file a complaint with our office you can do so by writing to:

Custodian of Records
LifeWorks Counseling Center
2625 N. Josey Ln., Suite 250
Carrollton, TX 75007

You will not be penalized for filing a complaint.

*Complaints and communications to the Federal Government*

If you believe that your privacy rights have been violated, you have the right to file a complaint with the federal government. You may write to:

Office for Civil Rights
US Department of Health & Human Services
150 S. Independence Mall West
Suite 372, Public Ledger Building
Philadelphia, PA 19106-9111
Email: ocrcomplaint@hhs.gov

You will not be penalized for filing a complaint with the federal government.

By signing this document, you have read, understand, and agree to abide by the polices and procedures described above.

Signature of patient or legal representative: _____

If you do not have Adobe to create a digital signature, please initial for approval: _____

Please print name of client: _____

Relationship to client: _____ Date: _____

---

***For Office Use Only:***

Verified paperwork-office staff initials: _____

Verified credit card authorization-office staff initials: _____

# HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact your therapist at Lifeworks Counseling Center.

## OUR PRIVACY COMMITMENT TO YOU

Your privacy is of utmost importance to us. The information we have about you will be held to the highest levels of confidentiality. We are required by law to give you a notice of our privacy practices and to maintain the privacy of your confidential information. Unless you give us permission in writing, we will only disclose your information when we are ethically or legally required to do so.

## WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees. The practices described in this notice will also be followed by agency employees and/or volunteers you consult with by telephone.

## YOUR CONFIDENTIAL INFORMATION

This notice applies to the information and records we have about your counseling, mental health status, and the care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose information about you and describes your rights and our obligations regarding the use and disclosure of that information.

## HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

### Special Situations

We may use or disclose information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

### To Avert a Serious Threat to Health or Safety

We may use and disclose confidential information about you when necessary to prevent a serious threat to your health and safety or the health and safety of another person. We also may disclose information relative to the disclosure of past or present knowledge of child abuse, abuse of the elderly, or of persons with disabilities.

### Required by law

We will disclose health information about you when required to do so by federal, state or local law.

### Lawsuits and disputes

If you are involved in a lawsuit or a dispute, we may disclose information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose information about you in response to a subpoena.

## OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your confidential information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we may have obtained from you. If you give us Authorization to use or disclose confidential information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.