Authentic Healing and Counseling
7660 Woodway Drive, Suite 385, Houston, TX 77063
Phone: 281-501-0109 Fax: 713-391-8421
Email: Info@AuthenticHealingAndCounseling.com

CONFIDENTIAL REGISTRATION FORM

This information is to help us better understand you and your situation. Please fill it out as completely as you can. All information will be held in strict confidence.

THERAPIST NAME: _____

CLIENT INFORMATION: **DATE:** _____

Name: _____ Date of Birth: _____ / _____ / _____

Address: _____City: _____ Zip: _____

Home Phone: _____ Mobile: _____ Email: _____

Gender Identity: ☐ Male (Cisgender) ☐ Female (Cisgender) ☐ Transgender FTM ☐ Transgender MTF

Sexual Identity: _____ Preferred pronoun: ☐ She/Her ☐ He/Him ☐ They/Them

Ethnicity: _____ Race: _____

Religion: _____ Preferred language: _____

Relationship Status: _____ How did you hear about us?_____

Present Living Situation: ☐ Alone ☐ With Spouse/Partner ☐ With Friends ☐ With Roommate ☐ With Parents ☐ With Kids

INSURANCE INFORMATION (Skip if self-pay):

Primary Insurance: _____Phone: _____

Employer: _____Name of Subscriber: _____ DOB: _____ / _____ / _____

Policy ID #: _____Group #: _____ SSN: _____ - _____ - _____

Secondary Insurance: _____Phone: _____

Employer: _____ Name of Subscriber: _____ DOB: _____ / _____ / _____

Policy ID #: _____Group #: _____ SSN: _____ - _____ - _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship to Patient: _____

Address: _____City: _____ Zip: _____

Home Phone: _____ Mobile: _____ Email: _____

1.) I, the undersigned, accept financial responsibility for payment of all fees at the time of visit, unless other arrangements have been made with Authentic Healing and Counseling.
2.) AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize the release of any information regarding my condition or treatment to insurance company.
3.) AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.

_____ _____

Patient / Legal Guardian Signature **Date**

PRIMARY DOCTOR INFORMATION AND CLIENT HISTORY:

Name: _____ May we contact him/her? ☐Yes ☐No

Phone: _____ Fax: _____

1.) Why did you decide to come or why were you referred to counseling? _____

_____

2.) Have you sought counseling in the past? ☐Yes ☐No If you answered yes, please provide details here:

_____

3.) Have you been treated in an inpatient facility or hospital for any mental disorder or substance abuse issues? ☐Yes ☐No. If you answered yes, please provide details here: _____

4.) Are you currently taking any medication? ☐Yes ☐No If you answered yes, please list current medications and medications tried in the past 12 months here:_____

Please check all concerns that apply to you:

Relationship:

- ☐ Friendship problems
- ☐ Verbal conflicts
- ☐ Trust issues
- ☐ Sexual problems
- ☐ Relationship conflict/distances
- ☐ Suspicious about other people
- ☐ Divorce
- ☐ Premarital counseling

Sexual Health:

- ☐ Physical and emotional intimacy
- ☐ Low sex drive / sexual interest
- ☐ Performance anxiety
- ☐ Low sexual self-image
- ☐ Feel sexually repressed
- ☐ Minimal or no sexual experience
- ☐ Gender identity
- ☐ Sexual identity
- ☐ Internal conflict w/ erotic desires
- ☐ Problematic sexual behavior
- ☐ Sexual trauma
- ☐ Infertility
- ☐ PMS/PMDD
- ☐ Perimenopause/Menopause

Sleep Disturbance:

- ☐ Insomnia
- ☐ Sleeping too much
- ☐ Nightmares
- ☐ Acting out dreams
- ☐ Snoring
- ☐ Night sweats

Lifestyle:

- ☐ Gambling
- ☐ Goals not being met
- ☐ Financial troubles
- ☐ Debt/Financial trouble
- ☐ Decision-making
- ☐ Substance/Alcohol abuse
- ☐ Smoking/Tobacco use

Employment:

- ☐ Employment termination
- ☐ Long-term unemployment
- ☐ Difficult boss
- ☐ Co-worker difficulties
- ☐ Overwhelmed / to many duties
- ☐ Working too many hours
- ☐ Career change

Mental Health:

- ☐ Anxiety/Panic
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Hallucinations/Delusions
- ☐ Trouble controlling anger
- ☐ PTSD
- ☐ Other _____

Other:

- ☐ Physical problems
- ☐ Pain
- ☐ Irritability / Unable to relax
- ☐ Procrastination
- ☐ Low motivation
- ☐ Thinking/confusion/remembering
- ☐ Mixed feelings
- ☐ Shyness
- ☐ Guilt
- ☐ Impulsivity
- ☐ Self-harm (cutting/scratching)
- ☐ Hair pulling
- ☐ Parenting
- ☐ Grief/Loss
- ☐ Death/Dying

Nutrition:

- ☐ Excessive dieting
- ☐ Low body weight
- ☐ Overeating
- ☐ Vomiting after eating
- ☐ Using laxatives
- ☐ High sensitivity about eating

5.) Please provide other pertinent information here that will help your therapist better understand your situation so that they can come up with a more suitable treatment plan for you:

I certify the information provided is correct and I authorize services to be provided to the above-named patient:

_____ _____

Patient / Legal Guardian Signature **Date**

GENERAL INFORMATION AND PROCEDURES

This form provides information about our counseling relationship, procedures involved, and your authorized consent to treatment.

Length of Session: Sessions are scheduled for 50, 60, and 90 minutes.

Cancellations: Your session time is reserved for you and is taken seriously. **Except for emergencies or exceptional circumstances (at therapist's discretion), cancellations must be made 24 hours in advance to avoid being charged. You will be charged a full session fee (insurance or cash pay rate) for no shows and late cancellations.**

Fee Structure: The client is financially responsible for payment of fees, which will be collected at the time of service. The client will also be responsible for any portion of fees not reimbursed or covered by health insurance. In the event of an accrued balance, the client and therapist can negotiate a payment schedule.

Confidentiality: Information shared in session is held in strictest confidence according to federal law (Regulation 42 CFT Part 2). Exceptions include: legal obligations (such as child abuse, elder abuse, testimony required by a judge, personal danger to self or an identifiable victim); information provided to parents if the client is as minor; and consultation with supervising professionals. Advice may be elicited from professional peers in regard to your case, without revealing identity. Release of information to another professional may be done only with your written consent.

Client Privacy: Recent laws have been enacted for client privacy. It is important to know that emails and mobile phone conversations are not secure or guaranteed of privacy because they can be potentially intercepted. Therefore, by signing this document you understand that if we have correspondence by email or mobile phone, there is a potential for confidentiality to be compromised.

Counseling Approach: To get the most of counseling of therapy, it is important to assume responsibility for your experience. Therapists can only help you based on the information you provide. If you are like most people, you probably have some sensitive issues you are not comfortable discussing with others. Those are usually the things you most need to talk about with your therapist. Regular, consistent participation in treatment sessions, as well as any "homework" assignments will help facilitate the process, but no therapist can ethically guarantee achievement of your goals. Please feel free to ask questions about the process and let your therapist know if you are not satisfied with how it is progressing. Because of the nature of the therapeutic process, you may experience periods of emotional discomfort on the way to your goals. No single therapist is the best one for every client. If you do not feel your therapist is the right fit for you, we will be happy to help you with another referral in this or another office. You are free to discontinue treatment at any time. Your counselor recommends you notify them in advance, when the client is ready to end the counseling relationship, a closing session, for a healthy relationship closer.

Court Appearance Policy: In the event you request the therapist serving you or your family member to appear in court, there is an up-front non-refundable retainer of $3500.00. The retainer is for one case and will expire in one calendar year. The retainer will be debited at a rate of $300/hour with a 2 hour minimum, and 15 minute increments thereafter. At such time that the balance of the retainer falls below $300.00, a conference will occur to determine whether additional funds will be needed to complete the work. Additional funds will occur in amounts of $800.00 and are also non-refundable. If your therapist determines that the process creates a dual relationship, they reserve the right to terminate the therapeutic relationship with appropriate referrals made.

Medical Records/Letters: In the event you request the therapist serving you or your family member to write a letter or send your medical records on your behalf the rate is $150/hour charged in 15 minute increments.

As a client, I have read, understood, and agree to the terms and conditions of the information presented in this form as I enter into therapeutic process.

_____ _____

Patient / Legal Guardian Signature **Date**

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No Show and Pre-Authorized Charge Form

I authorize Authentic Healing and Counseling to keep my signature on file and to charge my Credit Card listed below for:

- **A one-time amount of a full session fee (insurance or cash pay rate) in the event that I miss a scheduled appointment or fail to cancel my scheduled appointment within 24-hours or:**
- **Counseling, Coaching, and Neurofeedback Sessions**

I understand that this form is valid for on-going visits unless I cancel the authorization through written notice to the service provider.

Customer Name: _____

Cardholder Name: _____

Card Type: ☐Visa ☐MasterCard ☐Discover ☐American Express

Account Number: _____

Expiration Date: _____ Card Verification Number: _____

Cardholder Signature: X_____ Date: _____

USE OF PRE-AUTHORIZED CHARGE FORMS

This form is a pre-authorization to charge credit card payments to your clients. You must sill complete the actual credit card charges, including getting an authorization from each transaction.

The information on this form is to be used to fill out your charge slips, as is authorized by the cardholder for payment of future or ongoing visits.

1.) The cardholder will be charged for:
   - **a.** Charges not paid by insurance, not to exceed a designated amount, for either the current visit, or for all visits within a year.
   - **b.** Recurring charges of a specific amount, to be charged on a scheduled bases between two designated dates.
   - **c.** A total fee, of a designated amount to be charged to the customer's card one time. (Missed appointment fee)

2.) Personal information must be completed by the provider, stating the customer's name, cardholder's name, card type, account number and expiration date. Please be careful to note that the cardholder's date does not extend beyond the "ending date" for any recurring charges.

3.) The cardholder must sign and date the form.

4.) The form is valid for on-going visits unless the cardholder cancels authorization through written notice to the service provider.

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care options.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement of activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such 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.
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, 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.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- 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.

Client Rights/Confidentiality services will be rendered in a professional manner consistent with accepted legal and ethical standards. Information about you that is obtained during counseling sessions will not be revealed to anyone else without your consent except where disclosure is required by law. These instances include:

- Where there is reasonable suspicion of physical/sexual abuse to children or elderly persons
- Where you present a serious danger to yourself or others
- Where a court orders the counselor to disclose information
- If at any time for any reason you are dissatisfied with our services, please let us know. We also reserve the right for consultation with other professionals whenever believed necessary.

We are required by law to maintain the privacy of your protected health information and to provide you with notice on our legal duties and privacy practices with respect to protected health information. (Continued on page 6)

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:
US Dept. of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201
Toll Free: 1-877-696-6775

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read, and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Client Name/Guardian: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgment of this notice but was unable to do so as documented below:

Date:	Initials:	Reason:

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Consent of Non-Secure Forms of Electronic Communication

Electronic communication, via email, text and mobile phone between you and The Center for Authentic Healing and Counseling may not be secure. By signing below, you are acknowledging that you realize that email, text and mobile phone communication does not provide a completely secure means of communication. While The Center for Authentic Healing and Counseling will take reasonable efforts to protect your confidentiality, there is some risk that any protected health information contained in email, text or mobile phone may be disclosed to or intercepted by unauthorized third parties.

Your treatment will not depend on you giving consent. You also have the right to withdraw your consent to receive non-secure forms of electronic communications at any time.

Consent

By checking the boxes below and signing this consent, I give permission for Authentic Healing and Counseling to contact me using the non-secure methods indicated below even if the communication includes protected health information or other confidential information. I understand that email, text and mobile phone communications are inherently unsecure and that there are risks involved using these forms of communication:

Text communication:	Yes ( )	No ( )
Email communication:	Yes ( )	No ( )
Mobile Phone:	Yes ( )	No ( )
FaceTime	Yes ( )	No ( )
Skype	Yes ( )	No ( )

Print Client Name/Guardian: _____

Signature: _____

Date: _____

Authentic Healing and Counseling
Reveling In The Authentic You

Patient Responsibility- Insurance Disclaimer

Insurance Disclaimer: "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company, when applicable. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. We suggest to all patients that they contact their insurance to confirm that these services are covered.

Under this arrangement, you are responsible for paying your co-pay, any non-covered portions, and any deductible you have yet to cover. In addition, if your insurance company does not pay for our services, you agree to pay for the services provided in our clinic.

Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Print Client Name/Guardian: _____

Signature: _____

Date: _____