Carrie Gardner LPC
909 8th Street, Ste 309
Wichita Falls, Texas 76301
940-264-1212

Client Information

Date: _____

Name: _____ DOB: _____

Address: _____

City, State, Zip:_____

Marital Status: M S D W Sex: M F SS#: _____

Phone #: _____ Phone #2: _____

Spouse/ Parent Name: _____

Address & Phone #:
_____

Brief Description of reason for counseling:
_____
_____
_____
___

Responsible Party Information:

Name: _____ DOB: _____

Address: _____

City, State, Zip:_____

Employer: _____SS#: _____

Phone #: _____ Phone #2: _____

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Confidentiality Form

I, _____, request and give my permission for _____ to send correspondence, conduct conversations, and provide responses to the following individuals or entities regarding my medical information.

Professionals and/or Medical Providers:

1. _____

2. _____

3. _____

Individuals/ Family Members:

1. _____

2. _____

3. _____

Please Initial and date that you consent to the following statement:

_____ I allow Carrie Gardner to contact me via our secure telehealth platform.

Carrie Gardner and her staff have permission to contact me through the following methods:

Email: _____

Home #: _____ Cell #:_____

Date of release: _____ Client/ Guardian Signature: _____

Print name: _____ Relationship to patient: _____

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Information and Consent

I am pleased that you have considered me in selecting a counselor. This document is to inform you of my professional credentials and experience. I hope this will help you to understand the nature of our relationship. As your counselor, it is important I explain to you my licensing status as it pertains to the state of Texas. I have a master's degree in Mental Health Counseling, and am licensed by the State Board of Examiners of Professional Counselors with a counseling license.

Nature of Counseling

You have the right to choose alternatives and to participate in designing your own care plan.

My approach to counseling integrates biblical principles with secular theories in a way that utilizes empirically proven techniques and exercises while remaining true to scripture. My guidelines for your care plan take into account the spiritual, psychological, social, and biological dimensions of your life. The therapeutic relationship which we establish will be characterized by mutual respect and cooperation. One of my goals for you is to equip you to be with the tools to process and resolve problems more successfully, and with God's help, to come to a place of wholeness, where you can discern, process and resolve problems without my assistance or intervention. I will offer you principles and methods which you can utilize in the achievement of this goal.

Our sessions are going to be direct, intentional, and focused. Therefore, it is important to acknowledge that we have a professional relationship rather than a social one. Our contact through counseling will basically be limited to the sessions you arrange with me. If I happen to see you outside of our sessions at the office, I will avoid conversation about our counseling relationship in order to benefit you and myself.

You are entitled to an explanation of procedures in the helping session; so please feel comfortable asking questions when they occur. Also, please note that it is impossible to guarantee any specific results regarding your personal goals; however, together we will work to achieve the best possible results for you.

CONFIDENTIALITY

The information, which you tell me, belongs to you, not me; therefore, I will keep confidential anything you say to me with the following exceptions: 1) you direct me to tell someone else, 2) I determine that you are a danger to yourself or others. 3) I am ordered by a court to disclose information, 4) for consultation and supervision purposes or for backup when I am not available.

I am required by law to report incidence of physical or sexual abuse of a minor or the elderly.

It will be necessary for you to sign a consent form for release of information in the event you want any information released to another individual.

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REFERRAL POLICY

The process of helping you address specific areas of our life is unique. If inevitably it is the catalyst for several personal issues to arise that may cause some discomfort. This is a normal and natural part of the relationship process occurring between us. As the person chosen by you to be involved in this process I will help you work through this discomfort. To this end, I anticipate and desire a productive professional relationship with you.

If I believe that I do not have sufficient training or expertise to appropriately guide your treatment, I will refer you to someone who can.

In the event that a particular dissatisfaction with my services should arise, I am willing to discuss the nature of your dissatisfaction and make an attempt to move toward a solution for both of us. If we are unable to arrive at an acceptable solution, I will provide you with several possible referral sources.

FINANCIAL POLICY AND FEE ARRANGEMENTS

You have the right to know about any fees that you may be charged for services before those services are delivered and full explanations concerning fee policies.

1) The fees for my services and my professional time. The fee for a 50-minute session is $130 for the initial session and $90 for follow-up sessions.
2) The fee must be paid the day of the session, unless otherwise arranged with the office manager.
3) Visa and Mastercard, Cash or personal checks made payable to Carrie Andree are acceptable means of payment. If checks are returned due to insufficient funds, there will be a processing fee added to your bill. All fees are deposited to the counseling ministry and not to me personally.

There will be a charge for my time spent outside of sessions, such as letters of recommendation, referral information, consultations, interventions, depositions, or court appearances as an expert or regular witness or for other reasons.

Cancellation Policy

In the event that you will not be able to keep your appointment, you must notify the business office 24 hours in advance. If the office receives less than 24-hour notice of cancellation of a scheduled session, you will be obligated to pay a fee of $25. If you fail to show up for the appointment and no advance notice is given, you will be responsible for paying the no-show fee of $50.

If you have any questions, feel free to ask. Please sign and date this form to indicate that you have read, understood and consented to the information contained in it.

_____ _____
Carrie Gardner M.A. LPC Date

_____ _____
Client Signature Date

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Notice of Privacy Practices: This notice is to inform you of your rights in reference to the health insurance portability and accountability act of 1996 (HIPAA). The following categories describe different ways that we may use and disclose your protected rights.

Treatment: We may use your Protected Health Information (PHI) to provide and coordinate the services that you receive. For Example, we may contact you regarding compliance in such matters that require your signed consent for using your information in connection with your treatment.

Payment: We may use your PHI for various payment related functions. Example: We may contact your insurer in order to confirm and determine what benefits your policy contains and if our services can be covered as well as what your co-payment would be. When we bill your insurance for services rendered, the information on or accompanying the insurance claim may include information that identifies you and your diagnosis.

IN-House Operations: Your therapist may have the necessity at times to confer with another therapist concerning your therapy needs. This of course is kept in the strictest confidence between clinicians.

We are permitted to disclose your PHI for the following reasons: To communicate with individuals involved in your care or payment for your care. We may disclose to a family member, or other relative, close personal friends, or any other person you authorize PHI directly that is relevant to that person's involvement in your ase or payment related to your care. Should you authorize information to be sent via email, we cannot be held responsible for the security of the internet since we do not utilize a code system in transmitting email.

Victims of Abuse, Neglect, Violence: As licensed therapists, we are required by law to disclose to the proper government authority any activity that raises a suspicion of physical or mental abuse, neglect or exploitation. A therapist using professional judgement also must disclose information that is necessary to prevent serious harm to the patient or other potential victims. This information will be disclosed only to the extent required by law.

Other Uses and Disclosures of PHI: In such cases where a criminal court or criminal authority is involved with your case, if a subpoena is served, we are required by law to release a copy of records to the extent that the subpoena demands. If we are requested by you to release your PHI to another entity and subsequently that entity releases those records, a signed authorization of release will be obtained before we disclose your PHI for the purposes other than those provided for above (or otherwise permitted for or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation we will stop using or disclosing your PHI except to the extent that we have already taken action in reliance on the authorization.

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Your Health Information Rights:

You may request a copy of our current Notice of Privacy Practices at any time, even if you have received copies previously. You have the right to request additional information on our use or disclosure of your PHI by sending a written request to the privacy officer. We are not required to agree to such restrictions on uses or disclosures unless they are mandatory under state or federal law. You have the right to obtain a copy of the pHI that we maintain about you, however, any information we have obtained about you from a physician or therapist will not be released from our permanent record. You must contact that provider in order to obtain those records. To obtain a copy of your PHI, this office will only accept requests made in person with the appropriate ID, a government issued identification with a photo, such as drivers license or a passport. Documentations of the request, verification that the ID was tendered and confirmation of the mailing address will be placed in the patient's personal file. Records will be processed at the convenience of the office but under no circumstances will the process exceed the legal allowed 15 days. We may charge you a few for the copying and mailing the PHI or supplies that are necessary to fulfill your request. We may deny your request to inspect and copy in certain limited circumstances, If you feel the PHI we maintain about you is incomplete or incorrect, you may request that we amend it. To request an amendment, you must send a written request to the privacy officer. You must include a reason that supports your request. You have the right to receive an accounting of the disclosures we have made to your PHI after April 14, 2003, for most purposes other than treatment, payment or office operations. The right to receive an accounting of services rendered may be done by making a request, in writing, to the privacy officer. Your request must specify the time period. The time period may be longer than six years and may not include dates before April 14, 2003. For example, an incidental disclosure that may be overheard by the office support staff between you and your therapist. To reduce the likelihood of this happening, we recommend that you keep any of your conversions confined to your therapist's private office.

If you feel that your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services.

For clients choosing to utilize telehealth services, a secure HIPPA compliant service is used and records are maintained according to my state licensing.

_____ _____

Client Signature: Date: