

CONFIDENTIAL INFORMATION SHEET

Please fill it out as completely as you can. All information will be held in strict confidence.

Date: ____/____/____

CLIENT INFORMATION:

Name: _____ Birthdate: ____/____/____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Sex: ____ M ____ F Marital Status: _____ E-mail: _____

SSN: ____ - ____ - ____ (Required for us to bill your insurance) Referred by: _____

INSURANCE INFORMATION:

Insurance Carrier: _____ Phone: () _____ - _____

Employer: _____ ID # _____ Group # _____

Insured's Name: _____ Insured's DOB: ____/____/____

Insured's SSN: ____ - ____ - ____ (Required for us to bill your insurance)

RESPONSIBLE PARTY INFORMATION:

Name: _____ E-mail: _____

Relationship to client: ____ Self ____ Spouse ____ Child ____ Other (please indicate): _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

1. I, the undersigned, accept financial responsibility for payment of all fees at the time of visit, unless other arrangements have been made with the Accounting Department.
2. **AUTHORIZATION FOR RELEASE OF INFORMATION:** I hereby authorize the release of any information regarding my/my child's 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.

SIGNED: _____ DATE: _____
(client or parent if client is a minor)

Policies

Larry Malone, MA, LPC and Evelyn Malone, MA, LPC, LMFT provide services as representatives of Quantum Change Consultants, Inc., a Texas corporation in which they are both principal officers.

If you are using your healthcare insurance or other third-party payor, you are responsible for the co-payment stipulated in the payor's contract with the clinician. You may be charged for canceled appointments unless notice is received at least **24 hours** prior to the appointment time so that the time may be scheduled for another client. ***Payment is expected at the time of each visit unless prior arrangements have been made.***

NOTE: Insurance will NOT pay for "no-shows" or appointments canceled without sufficient notice. You are responsible for paying the full fee of \$140.00 in this event.

I understand and accept the policies concerning both the cancellations of appointments and payment for services. I will be responsible for the agreed upon payment due of \$140.00 per session.

X _____ Date: _____
(Client or Responsible party)

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 45- 50 minutes. This convention was established by insurance companies. Greater flexibility is possible and desirable, but may not be covered.

Cancellations: Your session time is reserved for you and is taken seriously. **Except for emergencies, cancellations must be made 24 hours in advance to avoid being charged.**

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. Additional cost may be incurred for use of assessment instruments or other materials.

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 a minor; and consultation with 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 the security of emails and mobile phone conversations cannot be guaranteed. Therefore, by signing this document you understand the potential privacy limitations if we correspond by email or mobile phone.

Counseling Approach: To get the most out of counseling or therapy, it is important to assume responsibility for your experience. Therapists can only help you based on the information you provide. Depending on the circumstances, you may be asked to include some family members in

your treatment. 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. 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.

Regarding email: With your authorization we will be happy to communicate with you using email to schedule appointments, send appointment reminders, to respond to your inquiries or for other professional purposes. Like any means of communication, email is not absolutely secure. We recommend that you not use your employer's email system for this. We place a high priority on your privacy. (See our privacy policy below) We do not sell or otherwise release client contact information. If you provide an email address to us or initiate email contact with us, this constitutes your authorization for us to communicate with you via email to your indicated email return address.

The signature below confirms that the information has been read and discussed with the therapist. I, _____, accept the policies listed above. I hereby give fully informed consent to therapist, Larry Malone and/or Evelyn Malone to enter into a psychotherapy relationship with me.

Client's Signature

Date

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 health 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 operations.

- **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. If you want us to seek reimbursement for our services from your insurance company, you authorize us to disclose to that payor confidential information necessary to obtain payment. We cannot be held responsible for how your insurance company uses that information.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement 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.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 1, 2005 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.

<p>Please contact us for more information:</p> <p>Quantum Change Consultants, Inc. 11702B Grant Rd., Suite 422 Cypress, Texas 77429 Phone: (832) 618-5156 Fax: (866) 330-3497</p>	<p>For more information about HIPAA or to file a complaint:</p> <p>The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 Toll Free: (877) 696-6775</p>
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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 and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

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 Private 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 health care 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.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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