3309 Unicorn Lake Blvd., Ste. 161
Phone: 940.382.0109

Denton, Texas 76210
Fax: 940.382.0482

Date: _____

Denton County Adult Probation Drug / Alcohol Evaluation
Client Information Form

Client Name:_____

Address: _____ City: _____ State: ____ Zip: _____

Date of Birth: _____/_____/_____ Client Age: _____ Gender: M or F

School Grade (if applicable):_____

Home Phone: _____ May we call you at home? _____Yes _____ No

Cell Phone: _____ May we call your cell phone? _____ Yes _____ No

Work Phone: _____ May we call you at work? _____ Yes _____ No

May we contact you via mail at the home address given above? _____Yes _____ No

If you would like to be contacted by **email instead** please provide your email address:

_____

In case of emergency, please notify (include address & phone number):

_____

Name/Contact Info. of Probation Officer:_____

Reason for referral: _____

Marital Status:

1. ____ Single
2. ____ Engaged
3. ____ Married
4. ____ Separated
5. ____ Divorced
6. ____ Remarried
7. ____ Widowed

How Long?

_____ Years _____ Months
_____ Years _____ Months
_____ Years _____ Months
_____ Years _____ Months
_____ Years _____ Months
_____ Years _____ Months
_____ Years _____ Months

Employment Status:

1. Employed full-time
2. Employed part-time
3. Unemployed
4. Full-time homemaker
5. Retired
6. Full-time student
7. Part-time student
8. Other _____

Place of Employment: _____ Occupation: _____

Please List All Household Members

Name:	Age:	D.O.B.	Relationship:
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____

Medical History

Currently under Doctor's care: Yes No

Doctors involved in your care/child's care (use reverse side if necessary): _____

_____

Health Problems (include allergies): _____

Medication currently used: NONE

Medication	Dosage	Prescribing Doctor	Reason prescribed
_____	_____	_____	_____
_____	_____	_____	_____

Past Hospitalizations:

Date(s)	Reason(s)	Hospital
_____	_____	_____
_____	_____	_____

Previous Counseling, Psychiatric Services or Chemical Dependency Services

Counselor/Facility Name	Date(s)	Reason(s)	Helpful?
_____	_____	_____	_____
_____	_____	_____	_____

Policies and Procedures

About Our Fees

- Usual and customary fees are $50.00 for a chemical dependency / substance abuse evaluation per the contract with Denton County Adult Probation (DCAP).
- Should counseling be recommended upon completion of your substance abuse evaluation, DCAP contractual fees are $50.00 a session
- Should your case require your assessor / clinician to go to court on your behalf, court testimony costs begin at $250.00 an hour with a minimum charge of three hours. A retainer of $1000.00 is ***due one week prior*** to the court date. Travel is billed at .50/mile. Failure to provide the specific fees as described constitutes a release from the requested court appearance.
- It is required that a minimum of 36 hours' notice be given if the testimony is not required, otherwise the entire retainer is forfeited. If proper notice is given, the retainer will be refunded.
- Additional services related to court preparation including all correspondence with attorneys or other service providers via phone, email or letter, documentation review and/or documentation preparation are also billed at $250.00 per hour, rounded to the nearest 15-minute increment.
- In cases where a therapist is being contracted to work with a child in a divorce/custody case, a certified copy of the temporary orders or divorce decree must be provided prior to the therapist beginning treatment.
- For a mental health/clinical evaluation (battery of assessments), usual and customary rates are between $700.00 and $900.00 whether ordered by the court system or requested from an individual. Cost is based on what is required in the battery. We do not accept insurance for any court ordered mental health/clinical evaluation.

Payment is to be made at the conclusion of each session and all checks need to be made payable to: ***LCC***. ***Please note that there will be a $25.00 fee assessed for any returned check.***

I understand that my fee will be $_____for the substance abuse evaluation or counseling services. **(Please initial _____)**

Client Commitment to Lifeway Counseling Center

LCC is committed to providing you with affordable and professional counseling services. To assist us with our efforts, we ask that you read and sign the following agreement:

Should I, _____ be remanded to counseling / therapy after my initial evaluation, I will make every effort to come for each counseling appointment. If it is necessary to cancel an appointment, I understand that this should be done at **least 8 hours**

in advance. Should I fail to notify the counselor and miss an appointment, I understand that the usual fee will be assessed and that it will be my responsibility to pay for the missed session. Further, should I need to reschedule an appointment, I understand that fees will be assessed based on the following schedule regardless of whether insurance is being used:

8 hour notice (or more) = *no charge*
Less than 8 hour notice = *35% of normal fee*
Less than 4 hour notice = *65% of normal fee*
Failing to show for appointment without notification = *full fee*

X_____ _____
Signature of client or parent/guardian *Date*

Statement of Confidentiality

A. **Confidentiality:** Under Texas law, a therapist / counselor cannot guarantee confidentiality under the following circumstances:

1. There is suspected or witnessed child abuse or a belief that a child may be in imminent danger of abuse/maltreatment
2. There is suspected or witnessed elder abuse or a belief that an elderly person may be in imminent danger of abuse/maltreatment
3. There is suspected or witness abuse of a disabled person or a belief that a disabled person may be in danger of abuse/maltreatment
4. There is a threat of suicide / homicide, in which case the counselor may contact the appropriate authorities who can help prevent harm
5. In response to a properly issued subpoena from the court or order from a presiding judge.
6. There is a request from the State Licensing Agency for the client's records. In this event, those records shall be made available for the purpose of insuring professionalism.

B. **Except as noted in A above,** no information regarding a client shall be released without the prior written consent of the client or in the case of a minor, the written consent of the minor's parent/legal guardian.

I have read & understand the limits to confidentiality _____ (initial here)

Any suspected violations of counselor ethics may be reported in writing to the following governing agencies:

TX State Board of Examiners of Professional Counselors OR TX State Board of Examiners of Marriage & Family Therapists
Complaints Management and Investigative Section
P.O. Box 141369 Austin, Texas 78714-1369

Disclosure Statement & Consent for Treatment

You have the right to competent, quality treatment that is consistent with professional standards established in practice and supported by research. Please be aware that the therapeutic process may involve personal awareness that may be emotionally painful, may cause heightened emotions, may cause anxiety, tension or stress and may cause some disruption or turmoil in your life as well as the lives of your significant others due to the subject matter being disclosed.

Counseling/therapy also has the potential to provide emotional support and stability for any family member involved in therapy. Further, it may relieve anxiety and create a safe environment for children or family members who are distressed. Finally, counseling/therapy has the potential for creating positive life changes in the form of long-term solutions to difficulties, and creating better communication. No guarantee can be offered for services as to results.

All communication with your therapist / counselor becomes part of the clinical record. Files are closed once the counseling relationship ends. Records for adult clients are destroyed seven years after the file is closed. Records for minor clients are destroyed seven years after the client turns 18 years of age. Records are the property of Lifeway Counseling Center. If at any time in the future you would like to request a copy of your records, you will need to submit a written letter of request in which your therapist / counselor has up to 15 days to produce copies (at a cost of $.50/page) for you. For more information on records request, please see the Texas Health and Safety Code, Title 7, Subtitle E, Chapter 611.

All clinical records are stored and maintained according to HIPAA guidelines. As a consumer of mental health / behavioral health services, you have certain rights under HIPAA guidelines. By signing below, you are attesting to the fact that you have read and that you understand the HIPAA guidelines as outlined in the HIPAA notice posted on our website and/or in our office.

Finally, we do not provide 24-hour crisis stabilization services. If you experience a crisis, please contact 911 or immediately go to your nearest emergency room. You may also contact the Denton County MHMR Crisis Hotline at: 1.800.762.0157.

I have read and understand all the above statements (**session / court fees**, **client commitment**, **limits to confidentiality** & **the disclosure statement**) and I / WE VOLUNTARILY CONSENT TO TREATMENT.

Signature of self/parent/legal guardian: _____

Signature of spouse / witness: _____

Date: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name Lifeway Counseling Center, PLLC
Address 3309 Unicorn Lake Blvd, Ste 161
City Denton State TX Zip Code 76210
Phone (940) 382.0109 Fax (940) 382.0482

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.