Family Help Counseling and Seminars

Mary J. Lambrecht, M.S., LMFT

Client Registration

Today's Date: _____

Client Name: _____ Date of Birth: _____ Age: _____

Street Address: _____

City/State/Zip: _____

Social Security Number: _____ Occupation: _____

Employer or School Name: _____

Phone Home: _____ Work: _____ Cell: _____

Emergency Contact: _____ Cell: _____

May we leave a message at the following? (Please circle yes or no)

Home: Yes No Work: Yes No Cell: Yes No Email: Yes No

Email Address: _____

Please do not cancel appointments by email. You must call me directly at (832) 953-4030.

If you would like to use a mailing address other than your home address for billing and correspondence, please provide that here: _____

How did you hear about Family Help Counseling? (Please circle all that apply)

Church: _____ Friend Spouse Work Relative Internet Seminar Brochure Minister/Priest Other: _____

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Consent for Treatment Form

I have been provided a copy of the Family Help Counseling and Seminars policies and procedures concerning:

- Informed consent for treatment
- Confidentiality
- Office procedures
- Financial policies
- Policies to protect the privacy of your health information

I have read and hereby agree to the policies and procedures as written, and I grant consent to Family Help Counseling and Seminars to contact me as specified and for the use and disclosure of my health information as described in those policies and procedures.

_____ _____

Client or Authorized Representative Signature Date

_____

Printed Name

Consent for Treatment

Client Name: _____ Date of Birth: _____

I hereby voluntarily consent to mental health counseling by my therapist. I have relied on my therapist for information in this regard and acknowledge that no warranty or guarantee has been made as to result or care. This form has been fully explained to me, and I certify that I understand its contents.

Client Signature: _____ Date: _____

Minor Consent

As a parent, guardian, or managing conservator, I have provided the divorce decree or appropriate documentation if necessary to hereby authorize Family Help Counseling and Seminars to provide services for:

Minor Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

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Informed Consent Policies

Revised: February 1, 2024

I am honored that you have chosen Family Help Counseling and Seminars to assist you in your personal growth. I am committed to providing quality services to my clients and ensuring that you have the information necessary to make informed decisions about your treatment process. If you have any questions regarding anything on this form, please discuss them with me before signing.

Philosophy

Family Help Counseling and Seminars provides a professional and emotionally safe therapeutic environment. We welcome people of all ages and stages to learn practical, theoretically sound tools to better navigate relationship, family, and individual challenges. Sensitivity, professionalism, and respect for human dignity are fundamental to addressing mental health, relationship, and/or spiritual needs of individuals, couples, and families. We believe that through creating authentic, respectful relationships individuals, couples, and families can live healthier and more fulfilling lives.

Counseling/Therapy

The relationship that exists between a therapist and a client is professional rather than social. Therefore, contact with your therapist will only take place in the provision of a professional service. In order to assist in the needs of you or your family, it may be necessary to refer you to other agencies or professionals. If so, we will assist you in facilitating these referrals. Your written consent is required to disclose any information about you or your family to individuals outside of Family Help Counseling and Seminars.

Individual and family therapy is an opportunity for healing and personal growth. We believe that individuals can possess the ability to do what is necessary to take an active role in this process. The length of time needed for therapy and the amount of intervention required varies with each individual. In order to receive the maximum benefits of therapy, your regular attendance and participation is imperative. In most cases, therapy is completely voluntary, and you can discuss ending your therapy relationship at any time. However, we recommend that, when possible, all therapy relationships be ended in an appropriate and therapeutic manner, generally requiring a final session to allow for closure.

During the therapy process, your therapist may recommend books for you to read, offer handouts, or use techniques to facilitate personal growth. We encourage you to discuss with your therapist any approach, technique, or practice with which you have questions, concerns, or need clarification. Therapy can be a difficult experience for some people. The disclosure of past hurts or current struggles can cause a temporary increase in depressive or anxious symptoms. If this occurs for you, please discuss the symptoms with your therapist.

Scope of Practice

Your therapist has over 17 years of clinical experience and is a clinical fellow with the American Association of Marriage and Family Therapy. I have earned two master's degrees, in Marriage and Family Therapy and in Mental Health Counseling. In addition, I have post-graduate training in specialized areas of focus. Thus, I am equipped to help clients address a broad spectrum of relational, emotional, and psychological challenges. No therapist, however, is equipped to deal with all diagnoses. Based on my training and experience, the following diagnoses indicate symptoms that are beyond the scope of my best practices. When such a situation arises, I will work with you to refer you to a therapist who is better equipped to address your unique situation.

- Alzheimer's and other dementia
- Autism (depending upon the severity of the symptoms and ability of the client to respond to treatment)
- Borderline Personality Disorder
- Dissociative Identity Disorder (Multiple Personality Disorder)
- Narcissistic Personality Disorder
- Intellectual Disability (depending upon the severity of the symptoms and the ability of the client to respond to treatment)
- Primary Addiction (client will be required to undergo therapy for the addiction from another specialized provider in conjunction with the individual, couples', and/or family therapy that I provide)
- Refusal to comply with treatment recommendations (this will be discussed with the client, and referral to other therapists will be provided)
- Schizophrenia

Confidentiality

Confidentiality is described as keeping private the information shared between a client and his/her therapist. Therapy sessions are strictly confidential. Information regarding your therapy sessions will not be discussed without your permission. ***Please refer to the Notice of Privacy Policies and Practices that details under what circumstances confidentiality is limited.*** Individuals involved in group therapy are required to maintain the confidentiality of the other group members outside of the group sessions.

Consent to Disclose Information

At times, your therapist may need to consult with other professionals or agencies on your behalf. Your signed consent to disclose information to other agencies and/or individuals is required for that consultation to take place. Exceptions may include a subpoena by a court of law. If you have received or are currently receiving mental health services and/or psychotropic medications from another health care provider, we may request your consent to speak with those professionals and/or obtain copies of previous treatment records in order to coordinate your care. Providing treatment may depend upon our ability to communicate with these professionals.

Please read the entire Notice of Privacy Policies and Practices relating to protected health care information and records, and the Health Insurance Portability & Accountability Act (HIPAA) law of 1996.

Appointments

Therapy services are by appointment only. You are responsible for keeping your appointments and arriving on time. We retain the right to discontinue services if you have missed more than two consecutive appointments, if you do not pay your therapy fees in a timely manner, if you continually refuse to comply with treatment recommendations, if it is clear that you are receiving no benefits from therapy, if you exhibit abuse behavior, if you engage in criminal behavior on the premises, or if you knowingly violate the confidentiality of another client (e.g., in group settings).

We cannot allow unattended minors under age 12 in the waiting room. There are no nursery services available during therapy appointments. If you do not have childcare arranged, please call to reschedule your appointment.

Parents and/or guardians must remain in the waiting room during their child's therapy session, unless they accompany the child in the session.

Office Hours

Monday – Friday, 9:00 a.m. to 6:00 p.m. by appointment only.

Communication and Emergency Services

You can reach your therapist by calling the business number (832/953-4030). If I am unavailable or you have called after hours, you can leave a message. I will return your call at my earliest convenience. ***If you are in crisis and it is after hours, please call 911 or proceed to your nearest emergency room. You can also call the Tri-County 24-Hour Crisis Line: 800/659-6994.***

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Financial Policies

Revised: February 1, 2024

Financial Arrangements and Insurance

We, at Family Help Counseling and Seminars, are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment/insurance policies. **The client is responsible for payment of services at the time of service. You may pay with cash, check, or most major credit cards.**

Each insurance company's coverage is unique. We cannot guarantee any insurance company will cover the cost of services. A response time from insurance is normally two weeks, but could take up to six weeks. We must emphasize that, as health care providers, our relationship is with you, not your insurance company. While providing you with a completed claim form is a courtesy we extend to our clients, all charges are your responsibility from the date the services are rendered. Your questions regarding reimbursement by your insurance company should be directed to your insurance company. In situations of divorce or separation, the individual who enlists the services of Family Help Counseling and Seminars will be responsible for all fees. Clients with a prior balance at the time services are obtained will be asked to pay the prior balance in full before being seen.

Out-of-Network Insurance

If you have insurance, we may be in your policy's out-of-network plan. You may call the number on the back of your insurance card for information on your out-of-network coverage. You will be charged the full session fee, payable at the time of the appointment. As a courtesy to you, we can provide you with a completed claim form, which you may file with your insurance company. Your insurance company would then typically mail any insurance reimbursement directly to you.

Session Fees

The fee for an original intake session at Family Help Counseling and Seminars is **$225 (80-90 minutes).** The fee for therapy sessions thereafter is **$150 (50-60 minute session).**

Methods of Payment

We accept cash, check, and most major credit cards. We do not accept post-dated checks, nor will we hold checks for any length of time. We maintain your credit card information in your file at our office, so that we can charge your card automatically at the time of your appointment or for missed appointments or late cancellations. We do not store credit card information electronically.

Returned Checks

There will be a $25 fee assessed per check for any and all checks returned from the bank for any reason.

Missed Appointments and No-Shows

We see clients on an appointment basis and request that you call in advance so we can reserve time for you. We make every effort to honor all commitments and request that you extend the same courtesy to us and to our other clients by ***calling us at least 24 hours in advance, if you are unable to keep your appointment***. **PLEASE CALL THE BUSINESS NUMBER TO CANCEL APPOINTMENTS. EMAIL IS NOT MONITORED FOR CANCELLATIONS.** We make reminder calls; however, it is ultimately the client's responsibility to track their appointments. You will be charged the full fee for late cancellation or not attending the appointment, as our office often cannot fill your allotted time. We know there are emergencies due to circumstances beyond your control. Please notify us as soon as possible if you have an emergency.

Minor Clients

For all services rendered to minor clients, the adult accompanying the client is responsible for payment. If the parents are divorced, the parent that accompanies the minor is responsible for the payments, regardless of the custodial agreement. If the non-custodial parent accompanies the minor, arrangements can be made for the custodial parent to pay for the session ahead of time.

Information Change

Please advise me of any address, email, or phone number changes promptly.

Collection Procedures

I am available to help you with questions regarding our fees and financial policies. Once made in writing, agreements are binding. We consider payment by the client for services rendered to be an important part of the client's role in the client/therapist relationship. Prompt payment for services rendered is expected, and failure to comply or respond to communications from our office may result in discharge from the practice. Hence, unless you make prior arrangements, prior balances must be resolved before any therapy session.

Other Services

Legal Testimony: Please be advised that I do not provide consultation, evaluation, or legal expert testimony in child custody, child visitation, or molestation cases. I will assist you with a referral if you need these services. However, should I be ordered by the court to give my opinion, fees will be charged at the rate of $500, portal to portal. This includes, but is not limited to, all time involved for preparation, parking, mileage, travel time to and from court, time in court, and all other expenses involved in testifying. This fee will apply as well to depositions or interrogatories.

Consultation: Records review, consultation with clients, litigants, attorneys (in person, via phone, or by email), reports, waiting at court, or any other service provided will be charged at the rate of $150 per hour in 15-minute increments.

Miscellaneous: Charges for other professional services not related to legal testimony are prorated at the regular therapy fee per hour in 15-minute increments. These services include, but are not limited to, phone calls that exceed 15 minutes, insurance reports, third-party consultations, and correspondence. Off-site consultation includes travel time to and from the appointment.

I have read and understand the financial policy and fee schedule of Family Help Counseling and Seminars, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by mutual agreement.

Signature _____ Date _____

Credit Card Information

Name on card _____

Credit card number _____ Exp date _____

CVV (3-digit code) _____ Billing zip code _____

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Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Family Help Counseling and Seminars may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your general consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment" is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when your therapist consults with another health care provider, such as your family physician or mental health professional.
- "Payment" is when we obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- "Health care operations" are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within Family Help Counseling and Seminars that utilizes information that identifies you.
- "Disclosure" applies to activities outside of Family Help Counseling and Seminars, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes we have made about our conversation regarding a private, group, joint, or family therapy session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Abuse of the Elderly and Disabled:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a Therapist:** If you report to us any situation that constitutes sexual misconduct by a current or former therapist, then we are required to inform the licensing authority of the offending therapist.
- **Regulatory Oversight:** If a complaint is filed against me with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without written authorization from you or your personal or legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and Our Professional Duties

1. Client's Rights

- *Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosures of PHI about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeking our services. Upon your request, we will send bills or other correspondence to another address.
- *Right to Inspect and Copy:* You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in your therapist's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny you access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend:* You have the right to an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- *Right to an Accounting:* You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorizations (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.

2. Our Professional Duties

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and practices, we will post a current copy in our offices. A current copy will always be available on our website and you may request a personal copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your record, or have other concerns about your privacy rights, you may contact me at (832) 953-4030.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Family Help Counseling and Seminars, 26205 Oak Ridge Drive, Unit 113, Spring, Texas 77380.

You may also send a written complaint to the Texas Department of State Health Services, Investigations, PO Box 141369, Austin, Texas 73714-1369 or call (800) 942-5540

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on September 1, 2016. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in our lobby and on our web site. You may request a personal copy at any time.

VII. Coordination of Care Between Health Care Providers and Release of Information

Communication between behavioral health care providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your therapist to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Client Rights

- You may end this authorization (permission to use or disclose information) any time by providing a written revocation request.
- If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on previous permission.

- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Client Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health, and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified client. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives this request.

Family Help Counseling and Seminars (Mary J. Lambrecht, M.S., LMFT) is authorized to release protected health information related to the evaluation and treatment of:

Name of Client: _____ DOB: _____

Primary Care Physician Name: _____ PCP Phone: _____

PCP Address: _____

Other Mental/Behavioral Health Provider(s):

Name: _____ Provider Phone: _____

Address: _____

Name: _____ Provider Phone: _____

Address: _____

Disclosure may include the following verbal or written information (check all that apply):

_____ All Records

_____ Face Sheet

_____ History and Physical

_____ Laboratory/Diagnostic Testing Results

_____ School Information

_____ Discharge Summary

_____ Medication Records

_____ ER Record Report

_____ Psychological Evaluation/Testing Results

_____ Psychosocial Assessment

_____ Psychiatric Evaluation

_____ Behavioral Health/ Psychological Consult Notes

_____ Substance Abuse Treatment Record

_____ Summary of Treatment Records and Conact

_____ Other

_____ I hereby refuse to give authorization for any release of information

_____ _____

Signature of Client, Parent, Guardian, or Authorized Representative Date

(If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law, e.g., Power of Attorney, Living Will, or Guardianship papers, etc.)