

12242 Queenston Blvd, Suite H (832) 287-3422

Houston, TX 77095 info@counselingcypress.com

 www.counselingcypress.com

**CLIENT INFORMATION
INFORMATION ON COUNSELING, INFORMED CONSENT, HIPAA,
24-HOUR CANCELLATION POLICY**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI \_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Male/Female

Please read the information provided in the master office copies of the Information on Counseling/Informed Consent/HIPAA/24 Hour Cancellation Policy; then initial and sign below regarding the following statements. A paper copy of the information found in the master office copies is available to you upon request. **Circle (Yes or No) if you would like a copy:**
**\_\_\_\_\_\_Mail, Telephone, and/or E-mail Consent**

I consent for Thomas Counseling Center, LLC and all of its agents to communicate with me by email, text or telephone at the addresses and telephone numbers provided above, and I will IMMEDIATELY advise the counseling center in the event of any change

**\_\_\_\_\_\_When Disclosure May Be Required**

Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the counseling records and/or testimony of our counselors.

**\_\_\_\_\_Confidentiality Between Family Members**

It is our policy, that in couple counseling and family counseling, when seen individually, information disclosed in individual sessions may be shared in joint sessions, confidentiality and privilege do not apply between the couple or among family members. It is also our policy, that information disclosed by a minor, may be shared with their legal guardian, though it is our practice to limit such disclosure as much as possible. BY SIGNING THIS INFORMED CONSENT, YOU AGREE THAT YOU ARE WAIVING YOUR CONFIDENTIALITY WITH RESPECT TO DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION IN SUCH CIRCUMSTANCES. THIS MEANS THAT YOUR

COUNSELOR MAY DISCLOSE WHAT WOULD OTHERWISE BE CONFIDENTIAL INFORMATION

THAT YOU DISCLOSE IN A THERAPY SESSION OR IN ANY DOCUMENTATION COMPLETED BY YOU OR YOUR COUNSELOR THAT ARE PART OF YOUR PROTECTED HEALTH INFORMATION RECORD. THIS WAIVER OF CONFIDENTIALITY BY YOU SUPERCEDES THE INFORMATION CONTAINED IN OUR NOTICE OF PRIVACY CURRENTLY IN EFFECT, AND BY YOUR SIGNATURE, YOU ACKNOWLEDGE THAT THE WAIVER OF CONFIDENTIALITY CONTAINED IN THIS INFORMED CONSENT TAKES PRECEDENCE OVER ANY POLICY OUTLINED IN OUR NOTICE OF PRIVACY POLICY. We will use clinical judgment when revealing such information. We will not release records to any outside party unless so authorized to do so by all adult family members who were part of the treatment.

**\_\_\_\_\_Duty to Warn**

In the event that the undersigned therapist reasonably believes that I am in danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person about the potential danger and to contact the following person(s), in addition to medical and law enforcement personnel:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Emergency Contact Person(s) Relationship Telephone Number

**\_\_\_\_\_Hold Harmless**

In consideration for receiving counseling services from Thomas Counseling Center, LLC, I agree to fully hold harmless and release Thomas Counseling Center, LLC; Aaron Thomas, LPC; Lisa Thomas, LPC; and all of their directors, officers, contractors, and employees from any liability of any kind (including without limitation liability for negligence) resulting directly or indirectly from the counseling services. On behalf of myself and my family and dependents, I agree to indemnify Thomas Counseling Center, LLC; Aaron Thomas, LPC; Lisa Thomas, LPC; and their directors, officers, contractors, and employees from and against any such liability.

**\_\_\_\_\_Consent to Treatment**

I, voluntarily, agree to receive counseling and authorize the undersigned counselor to provide such care, treatment or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment or services that I receive through the undersigned therapist at any time. By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

**continues on back**

**Please list all current medical and psychiatric medications below (indicate “NONE” if applicable):**

Medication Dosage Start Date Side Effects If Yes, List Effects

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES/NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES/NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES/NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES/NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Texas Board of Examiners of Professional Counselors established the rules under which we provide services. The Board’s address and telephone number where you can report and violations is listed below:

**Texas State Board of Examiners of Professional Counselors**

**1100 West 49th Street Austin, Texas 78756-3138**

**(512) 834-6658**

**Court Related Fees and Services**

* Court testimony costs begin at $250.00 an hour with a minimum charge of three hours. A retainer of $750.00 is due before any court related services are provided
* 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.

I understand that my fee will be $\_\_\_\_\_\_\_\_\_ for each counseling session or $250 per hour for court related services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature (Responsible Party) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature (Witness) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date

**Notice of Privacy Practices (HIPAA)**

I have read and understand the policy and procedure of this office’s Notice of Privacy Practices. A paper copy of the information in the master office copies is available to you upon request.
**Circle (Yes or No) if you would like a copy:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date:

(or signature of parent, guardian, or legal representative)

Printed Name of minor

Your Printed Name

**24-Hour Cancellation Policy**

Please be sure to provide a minimum of 24 hours when cancelling appointments to avoid a full session charge being added to your account. Accounts with an accumulated balance will need to be paid prior to scheduling your next session.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Printed Name Signature of Client or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date

I have read the Information on Counseling/Informed Consent/HIPAA/24 Hour Cancellation Policy forms provided to me and agree to its contents and have initialed the above statements regarding this information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name (Please Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Guardian (if applicable) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

Office Use Only
Counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
First Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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**Credit/Debit Card Pre-Authorization Form**

I hereby authorize Thomas Counseling Center, LLC to keep my signature on file and to charge my credit card account noted below for counseling services/charges not otherwise settled with cash or personal check at the time of service. I also understand that my counselor does request a minimum of 24 hours for all canceled sessions to avoid a full session charge being added to my account.

I understand that I may withdraw this authorization to charge my credit card at any time in the future, by communicating my request to do so in writing.

By my signature below, I am authoring Thomas Counseling Center, LLC to charge my credit card in the absence of my card being present and to disclose dates of my attendance and cancellations to my credit card issuer in the event that I dispute a charge.

Please Print

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CW2#(3 digit #on back): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_