INTAKE FORM

Calleen Friedel, M.S. LMFT-S CEAP EAS-C SAP
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Please answer all of the following questions to the best of your ability.

1) Name: ________________________________ Today's Date: ___________
2) Email: ___________________________________
3) _Male _Female 4) Date of Birth: __________ 5) Age: ________
6) Home Address:
____
7) City: _____________________________ State: _______ Zip Code: _______
8) Home phone: __________________ 9) Cell phone: __________________
10) Work Phone: __________________
Is it OK to contact you at home? Yes No **OK to leave a message?** Yes No
Is it OK to contact your cell? Yes No **OK to leave a message?** Yes No
Is it OK to contact your work? Yes No **OK to leave a message?** Yes No

11) Employer/School:____

12) Marital or Legal Status:
Marital/relationship status (circle one): Married; Live with partner; Single; Separated/Divorced; Widowed; or Other: __________

13) Emergency Contact:____________________phone:_________________

14) YOUR CONCERN FOR TODAY:
____
15) WHAT HAVE YOU TRIED TO RESOLVE THE PROBLEM:
____
16) HOW DO YOU THINK I CAN HELP TODAY?
____

17) Are you willing to sign a ROI for me to contact your PCP if necessary?
___ Yes ____ No (If Yes, please fill out the form below)

Release of Information

________________________ ____________
Client Name Date of Birth

____
Street Address City State Zip Code

I hereby authorize
________________________Calleen M. Friedel____
to exchange and/or disclose information regarding the evaluation and treatment of the above named person to

Dr. ______________________________________PCP______________________________________
Name Relationship to Client

I specifically request that the following information be released/exchanged:

______ Attendance Only
__x___ Summary of Attendance and Progress
__x___ Treatment and/or Services
______ Referrals/Recommendations
______ Other: ____

The doctrine of the informed consent has been explained to me and I understand the contents to be released, the need for information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is voluntary and is valid for a period of time not to exceed one (1) year. I further acknowledge that I may revoke this consent at any time except where actions based on this consent have already been taken.

I agree that a photocopy/fax of this authorization is to be considered as effective as the original.

_________________________________ _________________________
Signature of Client/Guardian/Parent Date

__________________________________ __________________________
Signature of Clinician Date

Notice of Privacy Practices
Health Insurance Portability and Accountability Act (HIPAA)

The private practice of Calleen Friedel has the responsibility to protect the privacy of your personal and health information, as described in this notice. Personal and health information includes medical (or psychological) information and individually identifiable information, such as your name, address, telephone or social security number. Ms. Friedel is required by applicable federal and state laws to maintain the privacy of your personal and health information or "PHI."

Ms. Friedel will protect your privacy by, limiting how we may use or disclose your PHI; limiting who may see your PHI; inform you of our legal duties with respect to your PHI: and explain and strictly adhere to our privacy policies. These policies are in effect as of April 14, 2003, and will remain in effect until updated and until you receive notice of any changes. Ms. Friedel reserves the right to change these policies and the terms of this notice as allowed by state and federal laws, rules or regulations.

Uses and Disclosures of Client Personal and Health Information:
Ms. Friedel may disclose your PHI to insurance carriers in order to receive payment for claims for services provided to you by Ms. Friedel and/or her staff within the limits established by the Texas State Board of Examiners of Marriage and Family Therapists or other applicable licensing board.

Ms. Friedel may use your PHI to conduct quality improvements, including outcome studies and development of clinical guidelines, care coordination, case management or utilization management activities. Ms. Friedel may also use your PHI to review the competence of clinical staff, provide clinical supervision or clinical staff, or for business purposes such as customer service, resolution of your complaints, due diligence in connection with the sale or transfer of assets to a potential successor in interest.

Ms. Friedel may use your PHI to contact you with information about services, provided, appointment reminders, or for collection of co-pays or your account balance (if any).

Ms. Friedel may use your PHI to the extent necessary to avert a serious an imminent threat to your health or safety or the health and safety of others. We may disclose this information to the proper authorities, if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes or if you admit to the abuse or neglect of a child or dependent elderly person or vulnerable adult.

Ms. Friedel must disclose your PHI when we are required to do so by U. S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with privacy laws.

Ms. Friedel may disclose your PHI in response to a court order or subpoena, although every effort will be made to obtain your consent for the release of any person or health information, as required by confidentiality regulations as set by the Texas State Board of Examiners of Marriage and Family Therapists (TSBEMFT) or other applicable licensure boards.

Ms. Friedel may disclose your PHI to laws enforcement officials or personnel of a correctional institution if you are in lawful custody while receiving treatment.

Your Rights:
You have the right to review or obtain copies of your personal and health information, subject to the limitations of the TXBEMFT. Your request must be in writing and you may be charge a fee for copying of the record.

You have the right to request to receive a list of instance in which we, or our subcontractors disclosed your PHI for purposes other than treatment, claims processing and organizational operations.

You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not requited to agree to these additional restrictions, but if we do, we will abide by our agreement. You also have the right to terminate or amend previously requested restrictions. Requests for additional restrictions or request for termination of requested restrictions must be in writing.

You have the right to request that we communicate with you in confidence about your PHI by alternative means, such as sending reminders for appointments by mail instead of telephone calls. You must specify how we may contact you in writing, if you do not wish to telephone at your primary or secondary listed telephone numbers.

You have the right to request an amendment of your PHI. The request must be in writing and include the information to be amended. We may deny your request for an amendment if we do not create the information you want amended, we do not maintain the information or the information is accurate and complete. If we agree to the amendment, we will make a reasonable effort to inform others of the amendment and to include the changes in any future disclosures of that information.

You have ht right to receive a copy of this notice in either written or electronic form.

You have the right to file a complaint if you believe we have violated your privacy rights or you disagree with a decision we made about access to your PHI. A complaint may be registered with the TXBEMFT. You may also submit a written complaint to the U.S. Department of Health and Human Services (HHS). Ms. Friedel supports your right to file a complaint and will assist you by providing address information for the HHS, and we will not retaliate in any way if you choose to file a complaint with us, TXBEMFT or the HHS.

Written Authorization to Use or Disclose Your PHI:
Ms. Friedel will request written authorization from you to use your PHI or to disclose it to anyone for any purpose or situation not included in this document. You may revoke this authorization in writing at any time. Your revocations will not affect any use or disclosure permitted by your authorization while it was in effect. We will not disclose your PHI for any reason except those described in this notice without your written consent.

Acknowledgement of This Notice of Privacy Regarding Your PHI:
Your acknowledgement of this notice or privacy will be made a part of your medical record. Please sign and date below. You may request a copy of this notice at any time.

______________________________ ____________
Patient/Client Name Date

______________________________ ____________
Signature of Patient/Client or Legal Guardian (if minor) Date

Informed Consent

Below are listed some important facts regarding your treatment at Ms. Friedel's private practice. Please read them carefully. If you have questions, please address them with your counselor.

Services Provided: Ms. Friedel provides psychotherapy including assessment, treatment planning, consultation, and individual, couples or family therapy, as well as referrals for medical and community services, if needed. She will discuss with you the treatment choices best suited for your needs. The extent and duration of your treatment will depend upon your choice and the recommendations of Ms. Friedel.
Session Duration: A sessions lasts 45 to 50 minutes; a half session lasts 25 minutes.
Fee Information: Your co-pay is due at the beginning of session. Ms. Friedel will talk to you about insurance and the number of sessions authorized along with the amount of co-payment.
Cancellation Policy: If you need to cancel an appointment, please notify this office as soon as possible. A missed appointment without 24 hours advance notification will be charged $50.
Confidentiality: All information and records will be kept confidential, and will be held in accordance with state and federal laws regarding the confidentiality of such records and personal health information. However, records and/or information will be released regardless of consent under the following circumstances:

1. According to state and local laws, counselors must report all cases of physical or sexual abuse or neglect of minors or vulnerable adults, which may include witnessing domestic violence, to the appropriate agency.
2. According to the state and local laws, counselors must report all cases in which there exists a danger to self or others to the appropriate agency.
3. In the event that you, your dependent or household members are in need of emergency services and other medical personnel needs to be contacted while receiving services.
4. In the event that your records may be subpoenaed by court.

Right of Access to Records: Adult clients, and legal guardians of minors, including managing and possessory conservators, have the right to access the record of the services provided to them. Please discuss any questions you have about this with Ms. Friedel.
Emergency/On-call Services: For emergency services, you may call Ms. Friedel, however, if she does not respond in a timely manner, call 911 or go to your local emergency room. For life or death situations, please call 911.
Treatment of Minors: Treatment of children under the age of 18 will be provided with the consent of the legal guardian. By signing this consent form, the client acknowledges that he or she is the legal guardian (as established by the state or divorce decree) of any minor presented for treatment.
I have read and understand this statement of informed consent. I consent to treatment with Ms. Friedel with the knowledge of the above conditions.

__________________________ _______________
Client/Guardian Signature **Date**

__________________ _______________
Witness Signature **Date**

Credit Card Authorization Form

I, ___________________________________, guardian of _____________________________, authorize *Calleen Friedel* to charge my co-payment/co-insurance or **no show or less than 24 hour notice cancellation fees ($50)** directly to the credit card listed below. **For clients using EAP benefits, this will not apply.**

Intake: $______________________

Individual Therapy: $___________________

Family Therapy: $______________________

- Credit Card
  - Name on credit card (exactly as printed)

    ____
  - Billing Address for CC

    ____
  - City, State & ZIP

    ____
  - Credit Card Number

    ____
  - Expiration Date & CVV Code

    ____

This authorization is valid until sessions have ended with Calleen Friedel or I provided you with a written cancellation letter. All co-payments and no show/less than 24 hr. cancellation fees will be charged to above credit card by next business day.

Signature: ___________________________________Date____________

Witness: ____________________________________Date:___________