CLIENT INTAKE
HIPAA/HITECH & NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

SHERRY L. RANDOLPH, M.A., LPC-S
Amarillo Family Institute

COUNSELOR

I am a LPC (Licensed Professional Counselor) and have met the requirements by the State of Texas under the occupations code, chapter 503 that allows them to provide individual, couples, family and group services. I have a Master's degree level with additional credentials. My approach is an empathetic talk therapy approach that incorporates multiple therapeutic interventions such as Family Systems, Marital (if married), Contextual, Cognitive/Behavioral, Solution Focused, Emotion Focused and Restoration Therapy Models. Additionally, I seek to incorporate the faith of the clients along with aspects of spiritual formation such as prayer, bible study, worship, service, small groups, etc. into the therapeutic interventions if you desire.

CONFIDENTIALITY

I follow all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards to keep clinical records. These records and the information you share are carefully guarded with the exceptions noted in my "Notice to Privacy Practices" provided to you. However, it is Texas law that I have a duty to warn and protect the appropriate individuals if the counselee intends to take harmful, dangerous, or criminal actions against themselves or someone around them. Possible exceptions to the confidentially include but are not limited to the following situations: I am mandated to report any suicide attempts incidences of "reasonably suspected child abuse" (physical or sexual), elderly or disabled abuse, abuse of patients in mental health facilities, sexual exploitation, AIDS/HIV infection and possible transmission, criminal prosecutions, child custody cases, suites in which the mental health of a party is an issue to the Department of Social Services and/or the Police Department. Situations where I have a duty to disclose, or where in my judgment, it is necessary to warn or disclose are: fee disputes with my services and the Client, a negligence suit brought by the client against my practice, of the filing of a complaint with the licensing or certifying board. I may occasionally find it helpful to consult about a case with other professionals and if this should arise, your identity will not be revealed. In addition to your confidentiality being important to me, as I am ethically bound to keep the information confidential***. If you should meet a member of our staff and/or therapist in public, please know they will not acknowledge you unless you initiate contact. It is preferred that you decide whether or not to disclose your acquaintance to others.***

CONFIDENTIALITY OF ALL ELECTRONIC COMMUNICATIONS

Please know I will maintain your confidentiality to the best of their ability; however we cannot guarantee this with ***any*** electronic communication. This includes but is not limited to the following: Email, Skype (or any other face time service), chat, texting, mobile devices, cell phones or fax.
If electronic communication is disrupted, please call your therapist at 806-374-5866.

INCAPACITY OR DEATH

In the event of my incapacitation or death, it will be necessary to assign your case to another therapist and for that therapist to have possession of your treatment records. If you would like your records sent elsewhere, a separate release will need to be signed.

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MINORS

Minors must have parental consent for counseling with the exception that the client: is 16 years of age or older and resides apart from the parents/guardians and manages his/her own financial affairs; is thinking about suicide; has concerns about alcohol or drug addiction/dependency; or is being sexually, physically, or emotionally abused. Consenting parents have the right to examine the treatment records of children under the age of 18; however, in order that minors may have the trust of a protected environment, it is your therapist's practice to ask parents to forego that right (they are willing to discuss progress with the parent/guardian) with the exception of extreme circumstances (see confidentiality above). At the termination of treatment and upon request, I will provide the parent(s)/guardian(s) with a summary of treatment. It is important to note that in the state of Texas children under 17 may not have consensual sex (by law it is considered indecency with a child and therefore "child abuse'') and the state requires a therapist to breach confidentiality and report such activity to Child Protective Services. If your therapist is required to make such a report to CPS about your child, you will be informed as well.

DUAL RELATIONSHIPS & SOCIAL NETWORKING

Not all dual relationships are unethical or avoidable. However, dual relationship situations might impair my objectivity, clinical judgment, or therapeutic effectiveness, thus will not be encouraged.
Please be aware that my social networking sites are utilized as a "blog" and not intended to replace personal counseling sessions. In regards to my personal social networking sites, I will not accept your invitation in the interest in protecting your privacy.

RELEASE OF INFORMATION

If information needs to be released it will only be done according to state law and with a written consent from the client indicating an informed consent of such release. In the case of marital therapy, the client is the couple, not individuals; therefore, all records can only be released when both parties consent in writing or if mandated by the court.

AVAILABILITY

In the event you encounter a personal emergency which will require prompt attention, my office will make every effort to accommodate and appointment. If your emergency arises after hours or on the weekend, clients are encouraged to contact a family member, call the Crisis Line at 806-359-6699, Family Support Services at 806-342-2500, call 911, or go directly to the nearest emergency department.

APPOINTMENTS

Subsequent appointments are scheduled with me during your session. Upcoming appointment reminders are available with your permission; however, it is your responsibility to keep or cancel the session(s). ***A 24 hour advanced notice for cancellations (non-emergency situations) is required to avoid a session fee. You (not your insurance company) will be charged $130.00.***

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APPOINTMENTS *(Continued)*

Due to our confidentiality policy, excluding minors, we are unable to schedule, confirm, adjust or cancel an appointment from anyone other than the client being seen unless a signed release is on file. If you and your spouse/partner are being seen together for the indicated session, it is acceptable for one party to schedule, confirm, adjust or cancel an appointment. However, we will not notify the spouse/partner of the appointment change. In the event of a family or medical emergency a note will be make on the account without disclosing information to a third party or family member unless a release is on file.

FEE SCHEDULE

Initial Evaluation (1st Visit): $150.00
Regular Office Visit (50 minutes): 130.00
Group Sessions (90 minutes): $50.00

In some cases, treatment may qualify you for your health insurance to reimbursement of Therapeutic Sessions. If you wish to file your health insurance for therapy costs, please contact my Office Administrator Pamela Counterman at 806-350-3133 so the benefit level may be established. Your insurance company will require a mental health diagnosis be placed on your health record at the time we file on your policy. Please feel free to address your concerns or questions with your Therapist. **Full payment is required until insurance information is established.**

RISKS & BENEIFTS

It is agreed that the client shall make a good-faith effort at personal growth and engage in the counseling process as an important priority at this time in his/her life. Therapy is designed to assist clients in resolving issues and dealing with painful life problems. I will make every effort to make therapy successful in this manner; however, you should know that therapy is no guarantee that you will "solve" your problems and that issues will be resolved. Furthermore please be aware, that through the course of therapy, we may expose issues that may cause additional problems to you and bring more life distress. Participation in therapy means that you accept these risks and are willing to deal with the potential problems. Suspension, termination, or referral shall be discussed for lack of commitment or for any unresolved conflict or impasse between therapist and client as soon as possible.

HIPAA/HITECH & Notice of Privacy Practice Acknowledgement:

My office is required by law to maintain the privacy of and provide individuals with a copy of my “Notice to Privacy Practices” of my ethical and legal duties in regards to your protected health information in all forms (i.e. all paper and/or electronic data). A copy is available in paper form and will be provided to you at no cost upon your request. . If you have any questions or objections to the Notice, please ask to speak with my HIPAA/HITECH Certified Office Administrator in person or by phone at 806-350-3133.

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By your signature you agree that you have read the terms and conditions of the informed consent & acknowledge you have reviewed the Notice of Privacy Practices for the office of Sherry L Randolph, M.A., LPC-S

Client's Printed Name: _____

Client's Signature: _____ Date: ____/____/____

Applicable for Marriage
Client's Printed Name: _____

Client's Signature: _____ Date: ____/____/____

Applicable for Minor's
Parent/Guardian's Printed Name: _____

Parent/ Guardian's Signature: _____ Date: ___/___/_____

Therapist's Printed Name: _____

Therapist's Signature: _____ Date: ____/____/____

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LITIGATION

In unusual cases, you may become involved in litigation that may require my participation. I will need adequate time to prepare for that participation; therefore, an advance notice of 2 weeks is required. This is to ensure my availability and cooperation.

At the time notice is received of a scheduled court date the following fees will become due for my professional time. All fees are to be paid prior to the scheduled court appearance. Please note you will receive and additional invoice for travel and meal expenses.

$800.00 – half day of professional time

$1600.00 – full day of professional time

In the event the court date is cancelled or rescheduled our office must receive notification ***72 hours in advance.*** Please call 806-350-5867 an If the required notice is provided, the responsible party will receive a full refund of paid professional time.

Failure to provide advance notice will result in your account being charged the full day of professional time as well as travel/meal expenses.

By your signature(s) you acknowledge you have read this notice and agree to the terms.

Client Printed Name: _____

Client Signature: _____ Date: ____/____/____

Applicable for Marriage
Client Printed Name: _____

Client Signature: _____ Date: ____/____/____

Applicable for Minor's
Client Printed Name: _____

Parent/Guardian Signature: _____ Date: ____/____/____

Office Staff Signature as Witness: _____ Date: ____/____/_____

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COUNSELING INTAKE FORMS

May we call, text or emails you? NO YES: Phone / Email / Text / All

Name: _____ Gender: M / F
Last First MI

Address: _____
Street City State Zip

Phone: _____
Home Work Cell

Email: _____

Birthday: _____ Age: _____

Status (circle): Married Separated Single Widowed Divorced / Student Employed Unemployed

Employer: _____ Length of employment _____

Occupation: _____ Gross income: _____

Spouse's name: _____ Birthday: _____

Spouse's employer: _____ Spouse's occupation: _____

Spouse's gross income: _____ Work phone: _____

Person to contact in emergency: _____ Phone: _____

Address: _____ Relationship to you: _____

Referred by: (circle one) minister, attorney, another client, relative, friend, other

Name of Referring Party: _____

Family physician: _____

Medications currently taken and their purpose (include non-prescription medications including sleeping pills, diet pills, aspirin, etc.). Please include dosage and schedule.

I hereby acknowledge that the information I have provided on this form is true and accurate.

_____ ____/____/____
Client Signature

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Insurance Fee/Information
(Please fill out if you are insured under someone other than yourself)

Primary Insurance Company: _____

Subscriber Name (if different from client): _____

Subscriber Relation to client: _____ M F Date of Birth: _____

Subscriber Home Address (if different from client):_____ City: _____ State: _____ Zip: _____

Subscriber Employer: _____

Insurance Card Number: _____ Group Number: _____

I hereby authorize the release of information necessary to Sherry L. Randolph and to the insurance company to file claims for payment. If incomplete information, inaccurate information or change of insurance without notification results in non-payment of claim or if for any reason insurance refuses to pay, I will be responsible for payment of entire fee. I also understand that I am responsible for applicable co-payments.

Signature: _____ Date: _____