

## CONFIDENTIAL

Do not read this document unless you are a client or guardian of a client who has completed this document, or a staff member of Wheelhouse Counseling.

# INTAKE PACKET

Updated 9/1/2020

People seek psychotherapy for many reasons; to heal from the past, to address the present and to prepare for the future. We are honored that you have chosen Wheelhouse Counseling to join with you in this process. Our work together will focus on your goals and values and shaping your life and relationships to support those goals and values.

Please complete the following packet in preparation for your first visit. Arriving to the initial session with this document complete will allow for more effective use of session time. This packet was tediously designed to be efficient and to not superfluously request information. Please note that all of this information will be protected in a confidential manner in compliance with HIPAA, HITECH, and Texas House Bill 300 regulations. You are encouraged to carefully read the document, as it contains essential policy and procedure information.

The information requested will help our work together. Please complete the packet to the best of your ability. If you feel uncomfortable with any portion of the form, leave it blank, and we can discuss your discomfort during our first session together.

## PERSONAL INFORMATION

Name: \_\_\_\_\_

(Last) (First) (Middle Initial)

Name of Parent/Guardian (if under 18 years): \_\_\_\_\_

(Last) (First) (Middle Initial)

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Gender:  Male  Female  Transgender

Vocation: \_\_\_\_\_

Number of Years in Current Job: \_\_\_\_\_

Marital Status:  Never Married  Domestic Partnership  Married  Separated  Divorced  Widowed

Preferred Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

May we leave a message?  Yes  No

Other Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

May we leave a message?  Yes  No

Personal E-mail: \_\_\_\_\_

May we email you?  Yes  No

Social Media:  Facebook  Twitter  LinkedIn  Instagram May we connect with you online?  Yes  No

\*\*\*Please note: Electronic correspondence (e.g., text, email, e-receipt, newsletter, social media, etc.) is not considered to be a confidential medium of communication. Please speak with your therapist about protecting your private health information (PHI).

Referred By (name & relationship): \_\_\_\_\_

## BILLING INFORMATION

Name on Card: \_\_\_\_\_

Card #: \_\_\_\_\_

Card Type:  American Express  Discover  MasterCard  Visa

Expiration Date \_\_\_\_/\_\_\_\_ CVV# \_\_\_\_\_

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

(Street and Number)

(City) (State) (Zip)

\*\*\*Please note: Receipts – paper or electronic – are available upon request. However, providing electronic receipts risks exposing your private health information. By requesting receipts electronically, you acknowledge the confidentiality risks in doing so.

## AUTHORIZATION FOR RECURRING CREDIT CARD CHARGES

For your convenience, you may authorize recurring charges to your credit card to pay for your therapy sessions. You will be charged the week of your therapy appointment unless other arrangements have been made. The charge will be made under the name *Brandon Wheeler Therapy*. By signing in this section below, you agree that no prior notification is necessary unless the amount billed each time exceeds \$500, in which case you will receive notification in advance

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify this practice in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date.

\_\_\_\_\_  
Client Signature (Client's Parent/Guardian if under 18)

\_\_\_\_\_  
Today's Date



## FAMILY INFORMATION

Emergency Contact: \_\_\_\_\_

Cell Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Relationship: \_\_\_\_\_

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

Are you currently in a romantic relationship?  Yes  No

Length of Current Relationship: \_\_\_\_ year(s) \_\_\_\_ month(s)

Name of Spouse / Partner: \_\_\_\_\_

Gender:  Male  Female  Transgender

Spouse / Partner Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Age: \_\_\_\_\_

Partner Vocation: \_\_\_\_\_

Number of Years in Current Job: \_\_\_\_\_

Please List Any Children / Dependents and All Others Who Live with You

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Relationship: \_\_\_\_\_

## PERSONAL & FAMILY HISTORY

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?  Yes  No

If so, was your experience helpful? Why or why not? \_\_\_\_\_

Are you currently receiving any type of mental health services (psychotherapy, psychiatric services, etc.)?  Yes  No

Other practitioner name and telephone #: \_\_\_\_\_

Have you ever been prescribed psychiatric medication?  Yes  No

Please list and provide dates: \_\_\_\_\_

Have you or a member of your immediate family struggled with (current or past):

	Myself	Family		Myself	Family
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Self-Discipline	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Panic Attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Phobias	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gambling	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ongoing Sadness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eating Disorder(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Self-Esteem	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suicide Attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anger	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unemployment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parenting	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
School Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Communication	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Domestic Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Forgiveness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



	Strongly Disagree	Disagree	Neutral or N/A	Agree	Strongly Agree
I am in good physical health.	1	2	3	4	5
I am satisfied with my weekly exercise routine.	1	2	3	4	5
I am satisfied with the amount and quality of my sleep most of the time.	1	2	3	4	5
I am satisfied with my food diet (balance, quality, etc.).	1	2	3	4	5

	Strongly Disagree	Disagree	Neutral or N/A	Agree	Strongly Agree
I am able to help my children learn from my life lessons.	1	2	3	4	5
I am satisfied with my children's stated goals and desires.	1	2	3	4	5
I am comfortable providing praise for others' accomplishments, including to my children.	1	2	3	4	5
I am comfortable receiving praise for my accomplishments, including from my children.	1	2	3	4	5

	Strongly Disagree	Disagree	Neutral or N/A	Agree	Strongly Agree
I am able to spend positive time with my family and friends weekly.	1	2	3	4	5
I have a support system that encourages good life habits and helps me accomplish my goals.	1	2	3	4	5
I have someone to talk to when I am stressed.	1	2	3	4	5
When I disagree with someone important to me, we are able to find a solution together.	1	2	3	4	5

	Strongly Disagree	Disagree	Neutral or N/A	Agree	Strongly Agree
I am satisfied with my current financial condition.	1	2	3	4	5
I am able to prioritize my financial goals.	1	2	3	4	5
My partner and I share financial goals/values.	1	2	3	4	5
I am confident in my ability to change my financial habits so that I can achieve my goals.	1	2	3	4	5
I am confident that I will achieve my long-term financial goals.	1	2	3	4	5

	Strongly Disagree	Disagree	Neutral or N/A	Agree	Strongly Agree
I consider myself a spiritual and/or religious person.	1	2	3	4	5
I rely on my spirituality and/or religion for strength and support.	1	2	3	4	5
I interact with people of my shared faith at least every other week.	1	2	3	4	5
My values shape my day-to-day activities.	1	2	3	4	5

What do you consider to be your best strengths? \_\_\_\_\_

\_\_\_\_\_

What do you consider to be your greatest personal challenges? \_\_\_\_\_

\_\_\_\_\_



# PSYCHOTHERAPY INFORMED CONSENT

This document contains important information about the services that will be provided to you as a client. Please read all the information carefully and ask any questions you may have about the content of this document. Upon signing this consent form, it will constitute an agreement between you and your therapist.

## LIMITS OF CONFIDENTIALITY

All information you share in therapy will be treated with great care. It is your right that our sessions and any confidential therapy notes about you are kept private. In all but a few rare situations, your confidentiality is protected by state law, the rules of the profession, and your therapist's personal integrity. Texas state law requires us to inform you that in certain cases your confidentiality is not protected, and your information may be disclosed to the appropriate authorities/agencies. Noted exceptions are as follows:

### Duty to Warn and Protect

When a client discloses intentions or a plan to harm themselves and/or another person, the mental health professional may be required to report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the mental health professional may be required to notify legal authorities and make reasonable attempts to notify the family of the client.

### Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child or vulnerable adult or has recently abused a child or vulnerable adult, or a child or vulnerable adult is in danger of abuse, the mental health professional may be required to report this information to the appropriate social service and/or legal authorities. If a client discloses that they themselves were physically or sexually abused as a child, the mental health professional may be required to report this information to the appropriate social service and/or legal authorities. This is the case even if the alleged abuser is deceased.

### Prenatal Exposure to Controlled Substances

Mental health professionals may be required to report admitted prenatal exposure to controlled substances that are potentially harmful.

### Minors/Guardianship

In most cases, parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

### Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes and summaries.

### Legal Subpoena

Records may be subpoenaed by the court if you are involved in a legal proceeding. Please understand that your right to privacy is waived when services are ordered by the court or to be used in court. Any communication made during your counseling and treatment is not protected, and may be disclosed at trial and to the parties of the suit. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for the therapist's time even if they are called to testify by another party.

### Family Secrets

When more than one individual is involved in the treatment process, a person may reveal a personal secret to their therapist without the other person(s) present. At no time will your therapist collude with some individuals against others.

(section continues to next page)



**Audio / Video Recording**

Neither client nor clinician is permitted to electronically record and/or broadcast any contact between client and clinician without a contract amendment signed by all parties involved and notarized validating authenticity of permission. All communication, within and outside of therapy sessions, is to remain absolutely confidential.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

\_\_\_\_\_  
Client Signature (Client’s Parent/Guardian if under 18)

\_\_\_\_\_  
Today’s Date

**THE THERAPEUTIC RELATIONSHIP**

Psychotherapy is a collaborative process between you and a therapist to work on areas of dissatisfaction and/or desired improvement in your life and assist you with life goals. For psychotherapy to be most effective, it is important that you take an active role in the process. The relationship between psychotherapist and client is the container through which change can take place. As such, the relationship is often one in which close emotional bonds develop. It is also a professional relationship in which appropriate boundaries must be maintained.

Because the therapist-client relationship is so important, you cannot be involved in an informal, social relationship or friendship that exists outside of the therapy room with your psychotherapist. Limiting this relationship to the therapy office keeps your therapeutic environment safe, secure and free of outside complications that could interfere with your therapy work. For example, your therapist will not interact with you via social media or other public forums so as to protect the therapeutic relationship.

I agree to the above understanding of the therapeutic relationship and agree to its expectations.

\_\_\_\_\_  
Client Signature (Client’s Parent/Guardian if under 18)

\_\_\_\_\_  
Today’s Date

**FIREARMS & WEAPONS POLICY**

Counseling can include highly emotional conversations, and therefore is an inappropriate place for firearms and other weapons. No client or visitor shall carry a firearm or weapon onto any part of Wheelhouse Counseling’s physical offices, including the parking lot, office spaces, and common areas.

I understand the above information and agree to the expectations described therein.

\_\_\_\_\_  
Client Signature (Client’s Parent/Guardian if under 18)

\_\_\_\_\_  
Today’s Date

**SESSION GUIDELINES**

In regards to session duration, sessions are colloquially called “one-hour sessions” but are intended to include no longer than fifty (50) face-to-face minutes, unless otherwise agreed upon prior to the date of the session. Additionally, ninety (90) minute sessions are also available to those clients who wish longer meetings. Some clients request longer sessions in order to accommodate complex family groups and other issues. Thirty (30) minute sessions are also available and can



be especially useful to individuals who wish to meet with a counselor during their lunch hour. Session length must be coordinated prior to the date of the session.

In regards to session fee, standard “one-hour” sessions are offered at \$130 per visit. Except in cases of life-or-death emergencies (as determined by your psychotherapist), phone call and video chat sessions cost full session fee. Sessions at 7am or earlier and 5pm or later may be considered “after hours,” and would be accompanied by a \$50 fee in addition to the standard rate. Weekend sessions may also considered “after hours.” Fees may vary. You should discuss your fee with your therapist before scheduling your first appointment.

In regards to the first contact, your psychotherapist offers 30 minutes of over-the-phone or face-to-face consultation free of charge. These free consultations are designed to help you learn how services may be able to address your concerns and/or goals. If you determine to continue sessions with your psychotherapist, you will do so at their established rate.

In regards to sliding scale fess, each therapist may agree to reduce their rate for providing psychotherapy services in particular situations though they are not required to do so. This personal matter should be discussed between you and your therapist during your initial consultation, during which a reasonable and mutually agreed upon fee should be determined.

In regards to cancellation of sessions, clients may cancel appointments through the online booking portal or by emailing info@wheelhousecounseling.com with “CANCEL APPOINTMENT” written in the subject line. **Cancellations within 48 hours of the scheduled appointment time include payment of the full session fee. If a client arrives 15 or more minutes late, the session will be canceled, and the client will be responsible for the full session fee.** Exceptions may occur in emergency situations, as determined by the clinician. If your psychotherapist must cancel an appointment due to illness or emergency, they will contact you to arrange for a new meeting date and time.

In regards to paying for sessions with your health insurance, your psychotherapist does not file your claims for you. However, your psychotherapist may be able to guide you how to be reimbursed by your health insurance Health Savings Account (HSA) or employer’s Employee Assistance Program (EAP) for the session fee. Whereas your psychotherapist is not familiar with your particular health insurance plan or employee benefits, they cannot guarantee reimbursement, but will work with you to determine the best payment option.

The psychotherapy process is unique to each individual. It inevitably will include discussing personal issues to arise that may cause some discomfort. This is a normal and natural part of the relational process occurring between a client and psychotherapist. If at any point you wish to terminate your work with your psychotherapist, you are free to do so. And if you would like their recommendation for a different clinician, they will provide a referral for you (name and phone number). Your psychotherapist may make a professional decision to discontinue your therapeutic relationship with them. If this happens, you will be given advanced notification and will be offered a referral to a different clinician.

I understand the above information and agree to the expectations described therein.

\_\_\_\_\_  
Client Signature (Client’s Parent/Guardian if under 18)

\_\_\_\_\_  
Today’s Date

**TECHNOLOGY-ASSISTED SERVICES (TAS)**

SERVICES PROVIDED BY WHEELHOUSE COUNSELING USING TECHNOLOGY:

- Video Sessions – If a session is not done in person, video is the preferred method for therapy sessions. It allows for us to see each other and to use our nonverbal communication.



- Phone Call Sessions – This form of technology is not the preferred method for entire counseling sessions, as we miss out on the nonverbal communication piece of therapy. However, we do still offer it for people who cannot otherwise meet with their therapist, either due to low bandwidth or discomfort in using video session technologies.
- Texting – Wheelhouse Counseling uses texting for matters pertaining to schedules only. We will text schedule information with you if you give us permission to do so here:  Yes, you have permission  No, do not text
- Email – It is best to communicate private health information (PHI) in-person. If this is not possible for you, you may email your therapist. However, the email systems used by Wheelhouse Counseling are not HIPAA compliant, and there is a security risk when communicating via email. If the emails are longer than a 5-minute read and response time, we will need to discuss how to bill for these exchanges (or perhaps adding more sessions to process the clinical material).
- Crisis Phone Calls/Texts/Emails – If the matter is an emergency, please call 911 or go to the nearest hospital. Wheelhouse Counseling is not equipped to handle psychiatric emergencies, and we would not be able to help you in times of crisis.

#### APPROPRIATENESS FOR USE OF TECHNOLOGY

In order to use technology services, our staff will be continually determining if using video or phone sessions are still appropriate to best serve you. At times, there may be a need for you to seek in-person help. If your therapist feels that you need in-person care, they will advise you to schedule in-person sessions. If it is not feasible for you to meet with your Wheelhouse Counseling therapist, they will provide you with 3 references for other clinicians.

#### SECURITY MEASURES

The security measures that Wheelhouse Counseling takes to ensure privacy are to use HIPAA-compliant technology as well as HIPAA-compliant behavior as much as possible. We take measures to protect your information, and we will spend time with you at the beginning and throughout our sessions to help you ensure that your sessions are being kept private on your end as well. When we use technology, the therapy room extends not only from where I am but to where you are as well.

#### BACK UPS TO CONNECT

Technology is wonderful... when it works!!! At times, our chosen method of communication might not work well (e.g., the video might be pixelated, the phone call might drop, etc.). If we are communicating by video and the picture is not loading properly, we will resort to phone. If we are communicating by phone and the quality is poor, we will hang up and call each other again. If a good line of communication cannot be established, we will have to end the session and try to establish a different way of connecting. If these methods routinely fail us, then we will have to consider a different way of doing therapy (i.e., either face-to-face or with a practitioner closer to you). This is a part of the ongoing evaluation of appropriateness of using technology services for therapy.

#### RISKS AND BENEFITS OF USING TECHNOLOGY SERVICES IN THERAPY

The benefits of using technology services for therapy are that you can easily get quality therapy services in the comfort of your own home, while traveling, and can avoid the hassle of traffic. If you are in an area where there are not many therapists, you can have a therapist see you from a different city in that state. If you have a therapist that you see face-to-face, but you or the therapist is moving cities, you can continue your work together.

The risks of using technology services is that there may be some difficulty due to internet or phone connection that might make communication difficult. There also may be some people who prefer face-to-face sessions, and they would need to be honest and open with their therapist about their preference. Use of technology services also requires a familiarity with technology that some might not have. Lastly, all forms of digital communication include some risk to privacy, including:





- The message can be observed by unintended audiences, such as if a spouse reads your emails/texts.
- Emails and texts can be misdelivered if sent to an incorrectly typed address or phone number.
- Accounts can be hacked, giving third party access to vulnerable information.
- Email providers (e.g., Google, Yahoo, Comcast) keep a copy of each email on their servers, where it might be accessible to their employees.
- Phone apps can search for identifying information and broadcast social connections.

**COLLECTION AND MAINTENANCE OF INFORMATION**

Wheelhouse Counseling stores client records in hard copy format in order to protect it from being stolen electronically. Your intake paperwork is not stored electronically. Your clinician’s progress notes may or may not be stored electronically, but all identifying information is removed from notes in to protect privacy. In accordance with psychotherapy ethical standards and the state licensing board’s rules and regulations, Wheelhouse Counseling maintains all records for seven years following termination of services (or seven years after the client reaches eighteen years of age).

**Do you consent to receiving electronic communication from your therapist?**     Yes     No

Authorization and Signature:

By signing here, you consent that you have read the above information and that you consent to using TAS.

\_\_\_\_\_

Client Signature (Client’s Parent/Guardian if under 18)

\_\_\_\_\_

Today’s Date

**RECORD-KEEPING PROCEDURES**

Your therapist may take notes during your session. These are informal progress notes used to assist the therapist in delivering effective, efficient service to you. They are kept confidential according to HIPAA, HITECH, and state regulations. If you prefer that your therapist not take notes, please voice that request at your earliest convenience and at any point during your psychotherapy. You are entitled to receive a copy of these notes, unless your psychotherapist believes that seeing them would be emotionally damaging to you. If this is the case, they will be happy to prepare an appropriate summary instead. Whereas client notes are informal documents, they can be misinterpreted and can be upsetting. If you insist on seeing your notes, it is best to review them with your therapist so that you can discuss their content. Clients will be charged a fee for any preparation time that is required to comply with a request for notes review.

If you are under 18 years of age, please be aware that Texas law provides your parents with the right to examine your session notes. It is policy to request an agreement from parents that they consent to give up access to your notes. If you agree, your psychotherapist will provide your parents only general information on how your treatment is proceeding unless there is a high risk that you will seriously harm yourself or another person. In such instances, your psychotherapist may be required by law to notify your parents of my concern. Parents of minors also can request to be provided with a summary of their child’s sessions when they are complete. Before giving your parents any information, your psychotherapist will attempt to discuss this matter with you and will do the best he can to resolve any objections you may have about what will be discussed. The State of Texas requires that your therapist keep your notes for seven (7) years after termination of counseling/therapy services and for minors, seven (7) years after the minor turns eighteen (18). Please note that your psychotherapist does not provide treatment of minors without their parents’ consent.



If the therapist's records experience a privacy breach (e.g., hacking of digital records), you are entitled to receive a notification of such an occurrence. This notice will be delivered if your PHI is viewed, used, or disclosed inappropriately.

The following uses and disclosures require a separate written authorization:

- Uses and disclosures for marketing purposes;
- Disclosures that constitute sale of PHI; and
- Any uses or disclosures not listed in this document.

If your therapist dies or is otherwise incapacitated, their clinical records will be transferred to another licensed marriage & family therapist in accordance with professional regulations. You will be provided the contact information for this documentation steward if such an event occurs.

I understand the above information and agree to the expectations described therein.

\_\_\_\_\_  
Client Signature (Client's Parent/Guardian if under 18)

\_\_\_\_\_  
Today's Date

### COURT APPEARANCES

In regards to the role of the therapist, our therapists cannot make recommendations about child custody or a judgement of parenting quality according to the ethical standards of the mental health profession. Fees for summary letters, disclosure of medical records, court appearances, preparations for court appearances and document submissions, and travel to-and-from court appearances are based in half-hour increments and cost \$125 per thirty minutes of work.

I understand the above information and agree to the expectations described therein.

\_\_\_\_\_  
Client Signature (Client's Parent/Guardian if under 18)

\_\_\_\_\_  
Today's Date

### GRIEVANCES

If you feel that your therapist has violated their professional ethics code and/or state law regarding their psychotherapy work, you can file a complaint to:

Texas State Board of Examiners for Marriage and Family Therapist (TSBEMFT)  
Complaints Management and Investigative Section  
P.O. Box 141369  
Austin, Texas 78714-1369

Or you can call 1-800-942-5540 to request the appropriate form or obtain more information. This number is for complaints only.

I understand the above instructions.

\_\_\_\_\_  
Client Signature (Client's Parent/Guardian if under 18)

\_\_\_\_\_  
Today's Date



## AUTHORIZATION TO RELEASE/OBTAIN PROFESSIONAL INFORMATION

### OPTIONAL

This form fully protects your civil liberties when the following conditions are met:

1. All blanks have been filled out prior to your signing it.
2. That you understand signing this is not required as a condition for treatment.
3. That you sign it only after a specific request for information has been made.
4. That the release of information is in your best interest, and
5. That you fully understand that the release is limited to include only the agency or individual named below.

I acknowledge that this information may be used in court. I authorize the staff of Wheelhouse Counseling to release and/or obtain professional information to and/or from:

Individual / Company: \_\_\_\_\_

Phone Number: (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_

In Regards To: \_\_\_\_\_

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

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

\_\_\_\_\_

(Street and Number)

(City) (State) (Zip)

#### Authorization and Signature:

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

\_\_\_\_\_  
Signature of Client (or Parent if Client is a Minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## AUTHORIZATION TO RELEASE/OBTAIN PROFESSIONAL INFORMATION

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The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (“HIPAA”).

1. Tell your mental health professional if you don’t understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as “Psychotherapy Notes.” All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client’s medical records to maintain a higher standard of protection. “Psychotherapy Notes” are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual’s medical records. Excluded from the “Psychotherapy Notes” definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. In order for a medical provider to release “Psychotherapy Notes” to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.



# OPTIONAL

It may be helpful for your therapist to have a clearer understanding of your family. A [genogram](#) is structurally similar to a family tree, but serves to highlight relevant issues and relationship dynamics in addition to lineage. You can find a guide for some basics at the bottom of the page. If you are willing, please take some time to draw out family information that you think relevant to our work together.

