Personal and Contact Information:

Last Name:_____First:_____Nickname_____

Date of Birth_____ Email:_____

Street address: _____

City: _____State: _____ Zip: _____

Primary phone number:_____Secondary phone number:_____

Emergency contact name:_____

Phone:_____relationship to client:_____

Referral Information:

☐ I was referred to you by a doctor, therapist or other professional:_____

Do you give me permission to thank this person for the referral? □ Yes □ No

☐ I found you on the internet.

☐ I was referred to you by a former/current client of yours.

☐ I was referred to you by somebody else.

☐ I found you in some other way:_____

Financial Agreement:

I understand that Jack Childers, LPC charges $150 per 50 minute hour, and that payment via cash , check or credit card is collected at the beginning of the session. I understand that I am solely responsible for the payment of clinical services rendered.

I understand that I can cancel or reschedule an appointment with Jack Childers, LPC with 24 hours notice without incurring any cancellation fees. I agree that if I give less than 24 hours notice, or if I miss an appointment altogether, I will pay Jack Childers, LPC the full cost of that session. I agree that, if Jack Childers, LPC is a network provider for my insurance, that my cost for a late cancellation or missed session will be the insurance contract rate for the service (my copay plus the insurance reimbursement). I agree to pay this amount by the time of the next session.

Client Signature: I understand and agree to all the terms described in this box.

Name:_____date:_____

Notice of Privacy Practices (Brief Version)

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

My commitment to your privacy

There are laws I am required to follow to keep your information private. These laws are complicated, and this is a shorter version of the full legally required notice of privacy practices. Please let me know if you want a copy of the full notice or if you have any questions or problems regarding this privacy notice. **However, I want you to know that, regardless of privacy laws, I am *personally* committed to doing everything in my power to keep your work with me private and confidential. I take your privacy, as my client, extremely important.**

How I use and disclose your protected health information (PHI) with your consent.

I will use the information I collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** If you want me to bill your health insurance provider for services I provide you, **signing this form gives me your authorization to release PHI to your health insurance provider**. If we want me to use or send, share, or release your information for other purposes, I will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require me to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.

2. When you give me information about child abuse/neglect or elder abuse/neglect.

3. When I am required to do so by lawsuits and other legal or court proceedings.

4. If a law enforcement official requires me to do so.

5. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. You can ask me to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, and not at work, to schedule or cancel an appointment. I will try our best to do as you ask.

2. You can ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information I have about you, such as your medical and billing records. You can get a copy of these records, but I may charge you for it. Contact me to arrange to see your records.

4. If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. You have to make this request in writing and send it to me. You must also tell me the reasons you want to make the changes.

5. You have the right to a copy of this notice. If I change this notice, I will post the new version in my office, and you can always get a copy of it from me.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. I will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or my health information privacy policies, please let me know.

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The effective date of this notice is January 1, 2010.

By signing, I acknowledge receipt of this HIPAA policy statement.

Signature_____Date_____