



Client Name: _____

New Client Profile

| | |
|--------------------|--|
| Today's date: | |
| Name: | |
| Date of Birth: | |
| Home Address: | |
| City, State, Zip : | |
| Home Phone: | Do we have permission to contact? Y N |
| Mobile Phone: | Do we have permission to contact? Y N |
| Work Phone: | Do we have permission to contact? Y N |
| Email: | Do we have permission to contact? Y N |

CHILD ONLY:

| | |
|-------------------------|--|
| School: | |
| Primary Care Physician: | |

Insurance Information:

| | |
|--------------------|---------------|
| Insurance Company: | ID & Group #: |
| Name of Insured: | Relationship: |

In Case of Emergency, Please Contact:

| | |
|-------------|---------------|
| Name: | Relationship: |
| Home Phone: | Other Phone: |

Please sign here to acknowledge that we have permission to contact them if an emergency, releasing confidential information: _____

Who referred you? _____
 Do we have permission to thank them? **Y N**

For Insurance Billing Purposes:

I the undersigned, certify that my dependent or I have insurance coverage with: _____ and assign directly to Mosaic Tree Counseling, all insurance benefits, if any otherwise payable to me, for I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Mosaic Tree Counseling, to release all information necessary to secure the payment of benefits. I furthermore authorize the use of this signature on all insurance submissions.

 Responsible Party Signature Relationship Date



Client Name: _____

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

For client _____ to expire on date (2 years from initial date) _____

Please consider, if applicable: Psychiatrist, Doctors, Probation Officer, Case Manager, Lawyer, CPS worker:

| Name | Title | Contact | Records | Initials |
|------------------------------------|---|---------------------------------------|-------------------------|-----------------|
| Mosaic Tree Counseling - personnel | Insurance, Biller, Administrator, Staffings | Ph: 713.969.8964 Fax: 888.959.6774 | All | X_____ |
| | Emergency Contact Listed (In case of emergency) | Ph: Alt Ph: | Pertaining to emergency | X_____ |
| | IF Applicable – School Counselor | Ph: Email: | All | X_____ |
| | | | | |
| | | | | |

By initialing the above, you are granting Mosaic Tree Counseling the ability to send or receive records requested via secure HIPAA compliant electronic mail, fax, and phone.

Sending information via text messaging on secure and encrypted phones:

*Does Mosaic Tree Counseling have your permission to text you or text limited information to any of the above initialed? _____

*Information via this mode would be limited to protect your Personal Healthcare Information in accordance with HIPAA (Public Law 104-191, 45 CFR §§ 164.524, 164.526, CFR § 164.501).

By my initials, I provide authorization for Mosaic Tree Counseling, to disclose information to the above named. You have the right to authorize or refuse coordination with your Primary Care Physician, Psychiatrist, Lawyer, School Personnel, Employee, or anyone else applicable. Disclosure may include records that have information regarding diagnosis and treatment of psychiatric disorders but is/are not limited to these areas. To the party receiving this information: This information has been disclosed to you from records whose confidentiality may be protected by Federal Law. If so, Federal regulations (42CFR, Part 2) prohibits you from and further disclosure of it without specific written consent of the person to whom it pertains.

| | | |
|--|---------------------------------------|---------------|
| _____ Client or Guardian Printed Name | _____ Client or Guardian Signature | _____ Date |
| _____ Witness Printed Name | _____ Witness Signature | _____ Date |



Client Name: _____

CONSENT FOR TREATMENT - Adult

I, _____, give my permission and consent to, Mosaic Tree Counseling, to provide psychotherapeutic treatment to myself.

Client Printed Name

Client Signature

Date

Representative Printed Name

Representative Signature

Date

CONSENT FOR TREATMENT - Child

I, _____, give my permission and consent to, Mosaic Tree Counseling, to provide psychotherapeutic treatment to my child,
_____.

Guardian Printed Name

Guardian Signature

Date

Representative Printed Name

Representative Signature

Date



Client Name: _____

CONSENT FOR TREATMENT- School

I, _____, give my permission and consent to, Mosaic Tree Counseling, to provide psychotherapeutic treatment to my child, _____ at _____ School. I also give my permission to Mosaic Tree Counseling to communicate with the School Counselor and the School Counselor to communicate to the Therapist. I understand that others at school may see that the child is in counseling when called from the office or pulled out of class. Mosaic Tree will try to provide the session during lunch time or elective; however, this is not always possible and could occur during a core subject, limited to 45 minutes during a week. I will also notify or my child will notify Mosaic Tree Counseling if he/she does not attend school, whether an illness or a holiday.

School Name _____, School Address _____

School Phone Number _____, Client's Grade Level _____

Client's Counselor _____, School Hours _____

School Lunch Time _____, School Elective Time _____

Client /Guardian Printed Name Client/Guardian Signature Date

Representative Printed Name Representative Signature Date



Client Name: _____

Primary Care Physician - Coordination of Care with Mosaic Tree Counseling

Please complete this form so we may communicate with your Primary Care Physician. If you do not want to disclose information, please check the box at the bottom and sign.

| CLIENT INFORMATION | | |
|--|---|-------------------------|
| Client's name: | Birth Date: | Type of Insurance: |
| Phone number: | If client is a minor, parent or guardian's name: | |
| Client's home address: | | |
| Primary Care Physician or Medical Provider Information | | |
| Primary Care Provider (PCP): | Address: | Medical Provider phone: |
| Medications: | | Medical Provider fax: |
| BEHAVIORAL HEALTH PROVIDER COMMUNICATION | | |
| Behavioral Health Provider (Therapist): | Mosaic Tree Counseling 2600 Gessner #203 Houston, TX 77080 713.969.8964 phone, 888.959.6775 fax | |
| Client Diagnosis: | Comments/Concerns: | |

I understand that I am not required to sign this authorization as a condition of receiving services from Mosaic Tree Counseling. The reason for disclosure is to facilitate coordination of treatment, which may include the diagnosis of mental health disorders. I understand that I may revoke this consent at any time. This consent expires two years from the date: _____

I give my authorization:

- To release mental health information to my medical provider from my Therapist to my PCP & to release any applicable medical information from my PCP to my Therapist
- I DO NOT give my authorization to release any information to my PCP and/or Therapist

Client or Parent/Guardian Signature: _____ Date: _____

| For Office Use | | |
|--|-----------|--------------|
| Date faxed to PCP/Medical Provider: _____ | By: _____ | Notes: _____ |
| <i>To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose.</i> | | |



Client Name: _____

Welcome to *Mosaic Tree Counseling*

Policies and Procedures

We would like to introduce these policies and procedures to you so that there are no misunderstandings in the future. Please ask any questions if you would like clarification.

1. Our initial meeting is for gathering information and setting goals and talking about ways that we might go about meeting them. If you don't want to continue treatment with us, please let us know within seven (7) days of our initial meeting and we will provide referrals.

2. We conduct Play therapy with younger children. When working with children we often involve the parents or the entire family during the therapy process, because greater involvement usually leads to quicker and better improvement in the child's behavior.

3. Each session will be about 45 minutes in length. If you arrive late to your session, that time will be taken out of our meeting. We will consider you a "no show" if you have not arrived or called 15 minutes past our appointment time. If you need to cancel or to reschedule an appointment, we require 24 hour notice. If the cancellation is not 24 hour notice, there may be a \$25 charge to continue services. After 2 "no shows," you may be terminated from services.

4. Payment is due at the time of the visit unless there have been other arrangements made. We accept cash, personal checks, and credit cards. You may choose to keep your credit card on file. It is your responsibility to discuss issues concerning your reimbursement with your insurance.

5. You have the right to terminate our relationship at any time, for any reason. Please give me seven (7) day notice if you decide not to work with me anymore. We also reserve the right to terminate our relationship, and will provide referrals to other therapists in that event.

6. Our discussions will remain confidential. The only exceptions to this rule are if you threaten to harm yourself or someone else, or in a response to court mandates.

7. We will strive to support you and/or family in the therapeutic journey as we work toward reaching set goals. Many clients do reach their goals, but we cannot guarantee this outcome.

8. You understand that these documents become property of Mosaic Tree Counseling, in that Mosaic Tree Counseling personnel may have access to your private information for purposes of insurance verifications, billing, authorizations, appointment calls, and staffing.

Client /Guardian Printed Name

Client/Guardian Signature

Date

Representative Printed Name

Representative Signature

Date



Client Name: _____

NOTICE OF PRIVACY PRACTICES

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. Your protected health information is information that is oral, written, or recorded in any form or medium that relates to your past, present, or future physical or mental health, the provision of healthcare, or the past, present, or future payment for provision of healthcare. This Notice concerns how we may use your protected health information and your rights to access and control it.

Our Uses and Disclosures

- We can use your health information to provide you with health care.
- We can share your health information to run our practice, improve your care, and contact you.
Example: We use health information about you to manage your treatment and services.
- We can use and share your health information to bill and get payment from health plans.
Example: We give information about you to your health insurance plan for reimbursement.

We are allowed or required to share your information in certain situations such as:

- Reporting adverse reaction to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- We will share information about you if state or federal laws require it, including the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- We can share health information with a coroner or medical examiner when an individual dies.

We can share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- In response to a court or administrative order, or in response to a subpoena



Client Name: _____

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Your Rights

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or summary of your health information, usually within 15 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.



Client Name: _____

Get a list of those with whom we've shared information with.

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us in writing at 2600 Gessner, Suite 203, Houston, TX 77080, Attn: Compliance Officer or by phoning us at 713-969-8964.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective date August 2018.

I hereby acknowledge that I have been presented with the Notice of Privacy Practices. This is to acknowledge that I have read and understand the Notice of Privacy Practices. I also acknowledge that I may obtain a copy of this at any time.

Client/Guardian Printed Name

Client/Guardian Signature

Date

Representative Printed Name

Representative Signature

Date



Client Name: _____

Client Rights & Responsibilities

The following is a list of some of the many rights you have as our client. You cannot be denied, suspended, or discharged from services for exercising your rights.

Human Rights

You have rights, benefits, and privileges guaranteed by law, and the right to be treated with dignity and respect. You will not be denied services because of your age, gender, race, spiritual beliefs, ethnic origin, marital status, personal or social beliefs, physical, developmental or mental disability, sexual orientation, HIV status, or financial status. You have the right to be free from abuse or neglect. Our Code of Conduct and Ethics prohibits physical abuse, sexual abuse, financial abuse, harassment, and physical punishment. This Code also prohibits psychological abuse, including humiliating, threatening, and exploiting actions.

Your Rights to Treatment

- You have the right to know the name and qualifications of our staff members.
- You have the right to receive information that will help you make decisions about your treatment. You have the right to state your preferences and make decisions about your mental health treatment, including agreeing to or refusing specific kinds of services.
- You have the right to participate in an Individual Treatment Plan based on your needs.
- You have the right to choose someone who can make decisions if you are unable.
- You have the right to refuse to participate in or be interviewed for research purposes.
- You have the right to terminate and/or refuse treatment at any time.

Client Responsibilities

- You must be receptive to therapy in order for therapy to be effective.
- Keep your information updated, and informing therapist of any changes immediately.
- Keep your scheduled appointments and let us know if you cannot keep your appointment.
- Be as honest and open as possible with your Therapist.
- Keep therapist informed of any concerns you have regarding counseling.
- Follow through with treatment plan, recommendations, and working on goals.

Client or Guardian Printed Name

Client or Guardian Signature

Date

Representative Printed Name

Representative Signature

Date



Client Name: _____

Mosaic Tree Counseling (Home-based Clients Only)

Confidential Area

It is important that the therapist and client are provided a private area to conduct the session.

Medical Safety

If the patient is medically ill or someone in the home of the patient is, it is the responsibility of the client or guardian to inform the therapist prior to arrival. It will then be up to the therapist to decide whether to conduct the session as scheduled or to re-schedule. If the therapist is medically ill or has something contagious, she/he will inform the client and guardians prior to arrival and it will be at the discretion of the client or guardians. Therapist reserves the right to cancel therapy at any time for medical safety.

Environmental Hazards

If therapist views anything in the home dangerous, she/he will notify CPS or appropriate authorities. This includes home sanitation, mold, and rodent/insect infestation.

Physical Safety

If therapist views a situation as unsafe, such as dimly lit parking lot, illegal activity, or feels her physical safety is being threatened, she/he has the right to re-schedule the appointment.

Play Therapy Sanitation

Play is conducted with younger children. Children often have difficulty expressing themselves verbally, and using therapeutic play can enhance their ability to process their emotions. All items are sanitized after every use and prior to every session through washing or sanitization.

Creative Art Therapy Materials

All materials used for creative art therapy are kid-safe and non-toxic, according to age. Some of these materials include paint, glue, scissors, and other creative art tools. For example, washable non-toxic markers are used for children under 13. No materials used will be dangerous, but may create a temporary mess that will be cleaned up prior to leaving. A designated area is preferred.

Anger Management Tools

Occasionally, severe anger management therapy is needed for children. While these are more aggressive means, if therapist feels this would be the effective approach, she will ask permission of parent/guardians.

Acknowledgement

This is to acknowledge that I have read, understand, and agree to the policies and terms. I also acknowledge that I may obtain a copy of this agreement at any time.

Client /Guardian Printed Name

Client/Guardian Signature

Date

Representative Printed Name

Representative Signature

Date



Client Name: _____

APPLICABLE IF YOU HAVE AN LPC-I OR GRADUATE INTERN COUNSELOR

An LPC-Intern is a professional counselor/therapist who has met all of the qualifications to become a fully licensed LPC including obtaining a graduate degree in counseling and passing the state licensure exam, but is still in the process of completing supervised counseling hours under the direct supervision of a Licensed Professional Counselor-Supervisor (LPC-S). An LPC-S is a professional counselor who has additional training and is licensed by the state of Texas to oversee the counseling work of LPC-Interns.

A Graduate Intern Counselor has completed a Master’s degree in counseling from an accredited graduate school, but has not yet passed the Texas State Board of Exam for Licensed Professional Counselors. A Graduate Intern Counselor works with a Licensed Professional Counselor-Supervisor (LPC-S) who is qualified to provide clinical supervision in the state of Texas.

Part of the supervision requirements includes review and discussion of client concerns in an effort to further the counseling skills of the Intern and assist him/her with providing you or your child the best care possible. The Counselor’s Supervisor is Maria Peters, MS, LPC-S (License #64866). You have the right to speak with her concerning your therapy or the therapy of your child.

By signing this form, I acknowledge I have been informed I will be receiving counseling services from LPC-Intern or Graduate Intern Counselor. I further acknowledge that I understand the qualifications of my counselor and the role of LPC-Intern or Graduate Intern Counselor. I understand that as a LPC-Intern or Graduate Intern Counselor, my counselor is under the professional supervision of Maria Peters, MS, LPC-S. I further acknowledge my understanding that as part of his/her training, my counselor may at times discuss information about our sessions with Maria Peters, MS, LPC-S.

Client or Guardian Printed Name Client or Guardian Signature Date

LPC-I/Graduate Intern Printed Name LPC-I/Graduate Intern Signature Date

LPC-S Printed Name LPC-S Signature Date