Catholic Counseling Services, Inc.

All information on this form is **CONFIDENTIAL INFORMATION**

Name of client:				**FOR OFFICE USE ONLY**	
SS #				**Case #:**	
Spouse:				**Counselor:**	
Maiden Name:				**Type of Service:**	
SS#:				**Fee:**	**Date:**
Address:		Apt. #		**Referred by:**	
City:		Zip Code:		**Parish:**	
Home Phone:		Work Phone:		**Type of Ins.:**	
Emergency Contact				**Stats:**	
Primary Care Physician:				Phone:	
Referring Physician:					
Health Insurance:		E-mail			

SELF		**SPOUSE**	
Age:		Age:	
Address: (if different)		Address: (if different)	
D.O.B.		D.O.B.	
Religion:		Religion:	
Yrs. Of Education:		Yrs. Of Education:	
Circle One:	Hispanic / Anglo / African-American / Asian / Native-American / Mixed-Ethnicity	Circle One:	Hispanic / Anglo / African-American / Asian / Native-American / Mixed-Ethnicity
Marital Status:		Marital Status:	
No. of times married:		No. of times married:	
Date of present marriage:		Date of present marriage:	
Place of Employment and Position:		Place of Employment and Position:	
Present Total GROSS Family Income:			

CHILDREN:

Name	D.O.B	Age	School or Place of Employment	Social Security #

Other Family Members living in the home:

Name	D.O.B	Age	Relationship to you

Have you ever been counseled by a member of the clergy?	Y	N
Have you ever been seen by a psychiatrist, therapist, or other mental health person?	Y	N
If yes, by whom and when?		
Are you presently being treated for any medical problems?	Y	N
If so, please indicate the type of problem(s):		
Have you been treated for illness or injuries in the past?	Y	N
If so, please indicate the type(s) of illness or injury.		
Are you presently taking any prescription medication?	Y	N
If so, what kind(s):		
How much and how often?		
Are you presently using any other drugs, nonprescription medication, or alcohol?	Y	N
If so, what kind?		
How much and how often?		

Briefly indicate your reasons for seeking counseling, or check the appropriate item(s):

_____Marriage problem _____Financial problem

_____Personal concern _____Separation

_____Family difficulty _____Other:_____

The information on this form is confidential and will not be released without the consent and approval of the client, or a court subpoena.

If you have a question about the professional performance of a social worker licensed by the Texas State Board of Social Worker Examiners call toll-free at 1-800-232-3162. In Austin, call (512)719-3521. Or write

Texas State Board of Social Workers Examiners
P.O. Box 141369
Austin, TX 78714-6718
http://www.dshs.state.tx.us/social work
1-800-942-5540 (Complaint Hotline)

_____ _____
Applicant's signature Date

_____ _____
Spouse's signature Date

_____ _____
Counselor's signature Date

Catholic Counseling Services, Inc.

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. This notice will also describe your rights and certain obligations we have regarding the use and disclosure of your health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

Your health information is personal. We are committed to protecting your health information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office whether made by your therapist or one of the office's employees.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

The following describes the different ways that your protected health information (PHI) may be used or disclosed by this office. "PHI" refers to information in your health record that could identify you. For clarification, we have included some examples. Not every possible use of disclosure is specifically mentioned. However, all of the ways we are committed to use and disclose your "PHI" will fit within one of these general categories:

- For Treatment. "*Treatment*" is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
- For Payment. "*Payment*" is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. We may also tell your health plan insurer about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover or continue to cover your treatment.
- For Healthcare Operations. "*Healthcare Operations*" are activities that related to the performance and operation of our practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management

and care coordination. We may use and disclose health information to provide you with appointment information. This may be done with voice mail, messages, post cards, and other mailings.

- Use. "*Use*" applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- Disclosure. "*Disclosure*" applies to activities outside of our office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse. If we have reasonable cause to suspect child abuse or neglect, we must report this suspicion to the appropriate authorities as required by law.
- Adult and Domestic Abuse. If we have reasonable cause to suspect you have been criminally abused, we must report this suspicion to the appropriate authorities as required by law.
- Health Oversight Activities. If we receive a subpoena or other lawful request from the Department of Health or the Texas State Board of Social Worker Examiners, we must disclose the relevant PHI pursuant to that subpoena or lawful request.
- Judicial and Administrative Proceedings. If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may use your PHI to defend the office or to respond to a court order.

- Law Enforcement. We may release PHI about you if required by law when asked to do so by a law enforcement official.
- Serious Threat to Health or Safety. If you communicate to us a threat of physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out that threat in the foreseeable future, we may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If we believe that there is an imminent risk that you will inflict serious physical harm on yourself, we may disclose information in order to protect you.
- Worker's Compensation. We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Social Worker's Duties

You have the following rights regarding the PHI that this office maintains about you.

- Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at our office. On your request, we will send your bills to another address.) To request confidential communications, you must complete our request form in writing and submit it to the Executive Director. We will accommodate all reasonable requests.
- Right to Inspect and Copy. You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. To inspect and/or obtain a copy of your PHI, you must complete our request form and submit it to the Executive Director. If you request copies, we will charge you $0.10 per page. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- Right to Amend. You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. To request an amendment, you must complete our request form and submit it in writing to the Executive Director. In addition, you must provide a reason that supports your request. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- Right to an Accounting. You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process. To request this accounting on disclosures, you must complete a request form and submit it in writing to the Executive Director. Your request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003.
- Right to a Paper Copy. You have the right to obtain a paper copy of the Notice from us upon request.

Social Worker's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact José Castrellón, LCSW , Executive Director at Catholic Counseling Services, Inc. (915)872-8424

If you have a question about the professional performance of a social worker licensed by the Texas State Board of Social Worker Examiners call toll-free at 1-800-232-3162. In Austin, call (512)719-3521. Or write:

Texas State Board State of Social Workers Examiners
P.O. Box 141369
Austin, TX 78714-6718
http://www.dshs.state.tx.us/social work
1-800-942-5540 (Complaint Hotline)

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you or penalize you in any way for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on February 1, 2013. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. If we revise our policies and procedures, we will post a copy of any revised Notice in this office.

Other uses and disclosures of your PHI not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to use or disclose PHI about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. Be aware that we are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of care that we provide to you.

ACKNOWLEDGMENT

By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices form.

_____ _____

Client/Parent/Guardian Signature Date

Refusal to Sign Acknowledgment

_____ _____

Patient Name Date

Notice of Privacy Practices was sent

_____ _____

Patient Name Date

Initials _____

Catholic Counseling Services, Inc.

499 St. Matthews Street • El Paso, TX 79907
Ph.(915) 872-8424 • Fax (915) 872-8425

CONSENT FOR TREATMENT

MENTAL HEALTH SERVICES	I consent for Catholic Counseling Services, Inc. to provide me/my marriage/my family with mental health services, which may include the following: evaluation, counseling and referral to other appropriate resources.
CONTACT WITH PRIMARY PHYSICIAN	I authorize Catholic Counseling Services, Inc. to contact my primary care physician in order to request and/or provide information regarding my treatment.
THIRD PARTY COVERAGE	I authorize any funding source, governmental agency, or private insurer to review my records for the purpose of determining if I received the services which were billed on my behalf.
EMERGENCY AFTER HOURS	If you experience an emergency, please contact the El Paso Psychiatric Center at 532-2202.
PATIENT'S OR AUTHORIZED PERSON'S CONSENT	I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of Government benefits either to me or to Catholic Counseling Services Inc. who accept assignment.
INSURED'S OR AUTHORIZED PERSON'S CONSENT	I authorize payment of medical benefits to Catholic Counseling Services Inc. for services provided.
BANKRUPTCY	I authorize Catholic Counseling Services, Inc. to contact the court/and my attorney in case I should file for bankruptcy.
CLIENT RIGHTS AND RESPONSIBILITIES	I have read and understood Catholic Counseling Services, Inc.'s statement on Client Rights and Responsibilities.

A FEE WILL BE CHARGED FOR ALL LATE CANCELLATIONS AND NO SHOW APPOINTMENTS THAT ARE NOT MADE WITHIN 24 HOUR ADVANCE NOTICE.

I understand that if I fail to sign this form, Catholic Counseling Services, Inc. will not be able to provide services to me.

Client Signature_____ Date:_____

Spouse's Signature_____Date:_____

Parent/Guardian _____ Date: _____

Witness:_____ Date:_____

Catholic Counseling Services, Inc.
499 St. Matthews Street • El Paso, TX 79907
Ph. (915) 872-8424 • Fax (915) 872-8425

CLIENT RIGHTS AND RESPONSIBILITIES

CLIENT RIGHTS

1. You and your family have the right to appropriate treatment by qualified staff and to know the qualifications and training of persons in charge of your treatment. You also have the right to be informed of any changes in staff involved in your treatment.

2. You have the right to appropriate confidentiality in therapy sessions and in Agency record keeping. All client files are kept in a locked cabinet. No information about you will be provided to individuals outside this Agency without your previous written authorization, with the following exceptions:
   a.) In case of a medical emergency.
   b.) When agency records are being examined by a funding, licensing, or accreditation body.
   c.) In case of suspected child abuse or neglect.
   d.) Should there be a court order pursuant to a subpoena, all related parties will be notified.
   e.) In cases where the client is in imminent danger of harming himself/herself or others.
   f.) Other specific exceptions as allowed by State and Federal law.

3. You and your family have the right to a treatment plan. You and your family may help develop the plan with the therapist. The treatment plan will be in writing, and you will be asked to sign it. It will be reviewed on a regular basis. You may request a review of the treatment plan at any point during services and/or you may wish to request a copy of the plan.
4. You have the right to refuse service at anytime, unless a court of law has decided otherwise.
5. You have the right to see and request a copy of your case record. This request must be made in writing. Arrangements for viewing your record can be made with your therapist, who will be present at the time of examination. Your Therapist will be available to explain materials which you do not understand, unless you should specifically request that assistance not be given.
6. If you have any complaints, these should be discussed with your counselor. If you cannot reach a satisfactory agreement with your counselor, you may appeal to the program supervisor. In general, you have a right to make a complaint about the services you receive if you feel your rights are not being upheld.
7. You have a right to know the cost of services your and your family receive, how much of the total cost of services to your family you are responsible for, and how much is paid by other sources, what those payments cover, and any limits or restrictions placed on your services. You will be asked to show proof of income at the time of the initial session. Fees will be discussed with you at the initiation of services and annually thereafter, and will also be re-evaluated should your personal circumstances change during the course of treatment. The cost per session is determined according to a fee scale established by Catholic Counseling Services, Inc. The fee per session is assessed in relation to family income.

CLIENT RESPONSIBILITIES

1. You are responsible for your participation in treatment according to the individual treatment plan agreed upon and signed by client and counselor.

2. You are expected to pay a fee in accordance with your financial capacity before the beginning of the session.

3. You are expected to act in a manner respectful of other clients, agency staff and property. Willful destruction of property or acts of violence against other clients or staff are not protected by confidentiality and will result in calling for police assistance.

4. You are responsible for bringing your children and remaining with those children under the age of 14, while they are treated at Catholic Counseling Services. If you have to speak to a counselor, you need to have a person looking after your children. Our staff does not babysit children in the lobby.

5. You are responsible for your child's behavior while she/he is at the agency and you will be held responsible for any damage caused by your child due to negligence.

6. You are responsible for fees which your insurance does not pay.

7. The market value of the counseling sessions is $150.00 per session. It costs the agency $127.00 to provide you with these services on a sliding scale.

8. **You will not be allowed to set further appointments if you have more than two unpaid sessions in your account.**

9. You are responsible for bringing in proof of income before your first session.

10. If you are on probation, court referred, or referred by your attorney, information regarding your case will not be released to the court, probation officer, attorney, or third party without a release and your balance is paid in full.

11. If your mental health records are subpoenaed by an attorney or court, the CCS staff will make every effort to inform you of your right to contract an attorney in order to have the subpoena quashed thus prevent your privileged information from being presented in court.

I have read and understand the Client Rights, my responsibilities during treatment, and the payment for services I receive.

_____ _____

Client's signature Date

_____ _____

Spouse's signature Date

_____ _____

Parent/Guardian signature Date

The following checked items must be provided before your appointment:

- ☐ 3 Check stubs
- ☐ Income tax form
- ☐ Medicaid letter
- ☐ C.H.I.P. card
- ☐ Medicare card
- ☐ Insurance card
- ☐ Utility bill in your name
- ☐ Picture I.D.
- ☐ Texas workforce commission letter
- ☐ Social Security award letter or copy of SSI or SS Check
- ☐ Proof or child support

You must arrive ½ an hour before your first appointment.

Date:_____ Time:_____

OFFICE HOURS: Monday, Wednesday & Thursday
9:00-12:00 and 1:00-6:00
Tuesday 9:00-12:00 ; 1:00-8:00 & Friday 9:00-12:00 ;1:00-5:00

Catholic Counseling Services
499 St. Matthews, Bldg. E. † El Paso, Texas 79907
Telephone 872-8424 † Fax 872-8425