# New Patient Information—Children and Adolescents (<18)

Client's name: _____Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____ Grade in school: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ Ext: _____

**If you need any more space for any of the following questions please use the back of the sheet.**

Primary reason(s) for seeking services:

___ Anger management ____ Anxiety ____ Coping ____ Depression

___ Eating disorder ____ Fear/phobias ____ Mental confusion ____ Sexual concerns

___ Sleeping problems ____ Addictive behaviors ____ Alcohol/drugs ____ Hyperactivity

___ Other mental health concerns (specify): _____

_____

**Family History**

**Parents**

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Were the child's parents ever married? _____ Yes ____ No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? _____ Yes ____ No

If Yes, describe: _____

**Client's Mother**

Name: _____ Age: _____ Occupation: _____ ____ FT __ PT

Is the child currently living with mother? ____ Yes ____ No

___ Natural parent ____ Step-parent ____Adoptive parent ___Foster home ____ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?

___ Yes __ No If Yes, please explain: _____

_____

**Client's Father**

Name: _____ Age: _____ Occupation: _____ ____ FT __ PT

Is the child currently living with father? _____ Yes ____ No

___ Natural parent ____ Step-parent ____Adoptive parent ___Foster home ____ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the father?

___ Yes __ No If Yes, please explain: _____

_____

**Client's Siblings and Others Who Live in the Household**

| Names of Siblings | Age | Gender | Lives | Quality of relationship with the client |
|---|---|---|---|---|
| _____ | ____ | ____ F ____ M | ____ home ____ away | ____ poor ____ average __ good |
| _____ | ____ | ____ F ____ M | ____ home ____ away | ____ poor ____ average __ good |
| _____ | ____ | ____ F ____ M | ____ home ____ away | ____ poor ____ average __ good |
| _____ | ____ | ____ F ____ M | ____ home ____ away | ____ poor ____ average __ good |
| Others living in the household | | | Relationship (e.g., cousin, foster child) | |
| _____ | ____ | ____ F ____ M | _____ | ____ poor ____ average __ good |
| _____ | ____ | ____ F ____ M | _____ | ____ poor ____ average __ good |
| _____ | ____ | ____ F ____ M | _____ | ____ poor ____ average __ good |
| _____ | ____ | ____ F ____ M | _____ | ____ poor ____ average __ good |

Comments: _____

_____

**Family Health History**

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

___ Allergies
___ Anemia
___ Asthma
___ Bleeding tendency
___ Blindness
___ Cancer
___ Cerebral Palsy
___ Migraines
___ Multiple sclerosis
____ Deafness
____ Diabetes
____ Glandular problems
____ Heart diseases
____ High blood pressure
____ Kidney disease
____ Mental illness
____ Other (specify): _____
____ Muscular Dystrophy
____ Nervousness
____ Perceptual motor disorder
____ Mental Retardation
____ Seizures
____ Spinal Bifida
____ Suicide

Comments re: Family Health: _____

_____

**Childhood/Adolescent History**

**Pregnancy/Birth**

Has the child's mother had any occurances of miscarriages or stillborns? _____ Yes ____ No

If Yes, describe: _____

Was the pregnancy with child planned? _____ Yes ____ No Length of pregnancy: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

Child number ___ of ____ total children.

While pregnant did the mother smoke? ____ Yes __ No If Yes, what amount: _____

Did the mother use drugs of alcohol? ____ Yes __ No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication)

_____ Yes ____ No

_____

**Infancy/Toddlerhood** Check all which apply:

___ Breast fed ____ Milk allergies ____ Vomiting ____ Diarrhea

___ Bottle fed ____ Rashes ____ Colic ____ Constipation

___ Not cuddly ____ Cried often ____ Rarely cried ____ Overactive

___ Resisted solid food ____ Trouble sleeping ____ Irritable when awakened ____ Lethargic

**Developmental History** Please note any developmental delays:

Comments re: delays

_____

Compared with others in the family, child's development was: _____ slow _____ average ____ fast

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

_____

_____

**Education**

Current school: _____ School phone number: _____

Type of school: ____ Public ____ Private ___ Home schooled _____ Other (specify): _____

Grade: _____ Teacher: _____ School Counselor: _____

In special education? ____ Yes ____ No If Yes, describe: _____

In gifted program? ___ Yes _____ No If Yes, describe: _____

Has child ever been held back in school? _____ Yes _____ No If Yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? _____ Yes _____ No

If Yes, describe: _____

Has the child been tested psychologically? ____ Yes ___ No

If Yes, describe: _____

Check the descriptions which specifically relate to your child.

**Feelings about School Work:**

___ Anxious ____ Passive ____ Enthusiastic ____ Fearful

___ Eager ____ No expression ____ Bored ____ Rebellious

___ Other (describe): _____

**Approach to School Work:**

___ Organized ____ Industrious ____ Responsible ____ Interested

___ Self-directed ____ No initiative ____ Refuses ____ Does only what is expected

___ Sloppy ____ Disorganized ____ Cooperative ____ Doesn't complete assignments

___ Other (describe): _____

**Performance in School (Parent's Opinion):**

___ Satisfactory ____ Underachiever ____ Overachiever

___ Other (describe): _____

**Child's Peer Relationships:**

___ Spontaneous _____ Follower ____ Leader ____ Difficulty making friends

___ Makes friends easily _____ Long-time friends ____ Shares easily

___ Other (describe): _____

Who handles responsibility for your child in the following areas?

School: ____ Mother ____ Father ____ Shared ___ Other (specify): _____

Health: ____ Mother ____ Father ____ Shared ___ Other (specify): _____

Problem behavior: ____ Mother ____ Father ____ Shared ___ Other (specify): _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? ____ Poor ___ Average ____ Good ____ Excellent

Current employer: _____ Position: _____ Hours per week: _____

How have the child's grades in school been affected since working? _____ Lower ____ Same ____ Higher

How many previous jobs or placements has the child had? _____

Usual length of employment: _____ Usual reason for leaving: _____

**Leisure/Recreational**

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

| Activity | How often now? | How often in the past? |
|---|---|---|
| | | |
| | | |
| | | |

**Medical/Physical Health**

___ Abortion
___ Asthma
___ Blackouts
___ Bronchitis
___ Cerebral Palsy
___ Severe colds
__ Severe head injury

____ Pneumonia
____ Heart trouble
____ Hepatitis
____ Hives
____ Influenza (flu)
____ Miscarriage
____ Diabetes

____ Meningitis
____ Pregnancy
____ Seizures
____ Congenital problems
____Sexually transmitted disease
____ Paralysis

___ Diphtheria
___ Dizziness
___ Ear aches
___ Ear infections
___ Other skin rashes

____ Multiple sclerosis
____ Vision problems
____ Muscular Dystrophy
____ Nose bleeds
____ Other

____ Wearing glasses
____ Fevers
____ Encephalitis
____ Eczema

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

**Most recent examinations**

| Type of examination | Date of most recent visit | Results |
|---|---|---|
| Physical examination | _____ | _____ |

_____

| Current prescribed medications | Dose | Dates | Purpose | Side effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

| Current over-the-counter meds | Dose | Dates | Purpose | Side effects |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Chemical Use History**

Does the child/adolescent use or have a problem with alcohol or drugs? ____ Yes ___ No

If Yes, describe: _____

_____

**Counseling/Prior Treatment History**

Information about child/adolescent (past and present):

| | Yes | No | When | Where | Reaction or overall experience |
|---|---|---|---|---|---|
| Counseling/Psychiatric treatment | ____ | ____ | _____ | _____ | _____ |
| Suicidal thoughts/attempts | ____ | ____ | _____ | _____ | _____ |
| Drug/alcohol treatment | ____ | ____ | _____ | _____ | _____ |
| Hospitalizations | ____ | ____ | _____ | _____ | _____ |

**Behavioral/Emotional**

Please check any of the following that are typical for your child:

___ Affectionate
___ Aggressive
___ Alcohol problems
___ Angry
___ Anxiety
___ Attachment to dolls
___ Avoids adults
___ Bedwetting
___ Blinking, jerking
___ Bizarre behavior
___ Bullies, threatens
___ Careless, reckless
___ Chest pains
___ Clumsy
___ Confident
___ Cooperative
___ Cyber addiction
___ Defiant
____ Frustrated easily
____ Gambling
____ Generous
____ Hallucinations
____ Head banging
____ Heart problems
____ Hopelessness
____ Hurts animals
____ Imaginary friends
____ Impulsive
____ Irritable
____ Lazy
____ Learning problems
____ Lies frequently
____ Listens to reason
____ Loner
____ Low self-esteem
____ Messy
____ Sad
____ Selfish
____ Separation anxiety
____ Sets fires
____ Sexual addiction
____ Sexual acting out
____ Shares
____ Sick often
____ Short attention span
____ Shy, timid
____ Sleeping problems
____ Slow moving
____ Soiling
____ Speech problems
____ Steals
____ Stomach aches
____ Suicidal threats
____ Suicidal attempts

___ Depression
___ Destructive
___ Difficulty speaking
___ Dizziness
___ Drugs dependence
___ Eating disorder
___ Enthusiastic
___ Excessive masturbation
___ Expects failure
___ Fatigue
___ Fearful
___ Frequent injuries
____ Moody
____ Nightmares
____ Obedient
____ Often sick
____ Oppositional
____ Over active
____ Overweight
____ Panic attacks
____ Phobias
____ Poor appetite
____ Psychiatric problems
____ Quarrels
____ Talks back
____ Teeth grinding
____ Thumb sucking
____ Tics or twitching
____ Unsafe behaviors
____ Unusual thinking
____ Weight loss
____ Withdrawn
____ Worries excessively
____ Other:
_____
_____

Please describe any of the above (or other) concerns: _____

_____

How are problem behaviors generally handled? _____

_____

Has the child/adolescent experienced death? (friends, family pets, other) _____ Yes _____ No

At what age? _____ If Yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

___ Yes ___ No If Yes, describe: _____

_____

Any additional information that you believe would assist me in understanding your child/adolescent?

_____

_____

Any additional information that would assist me in understanding current concerns or problems?

_____

_____

What are your goals for the child's therapy? _____

_____

What family involvement would you like to see in the therapy? _____

_____

Do you believe the child is suicidal at this time? _____ Yes _____ No

If Yes, explain: _____

_____

# New Patient Information

**Please Print Clearly** **THIS SHEET MUST BE FILLED IN COMPLETELY**

Date_____ Client's Social Security #_____

Client's First Name_____ Last Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____ (Ext)_____

Birthdate____/____/____ Age_____ Gender __F __M Race_____

_____Name of Spouse/Guardian_____ Phone_____

Address_____ City_____ State_____ Zip_____

Person Responsible for Payment_____ Soc. Sec. #_____

Signature of Person Responsible for Payment **X**_____ (Must be signed for services to begin)

**Emergency Information**

In case of emergency, contact:

Name (1) _____ Relationship_____ Phone_____Work_____

Address_____ City_____ State_____ Zip_____

Physician_____ Phone_____

Address_____ City_____ State_____ Zip_____

Psychiatrist_____ Phone_____

Address_____ City_____ State_____ Zip_____

Other Physicians_____ Phone_____

**Employment Information** (If client is a child, use parent's employment)

Client/Guardian: Place_____ Phone_____ Hrs____

Spouse: Place_____ Phone_____ Hrs____

**Insurance Information**

Primary Insurance_____ Secondary Insurance_____

Phone_____ Phone_____

Contract/ID#_____ Contract/ID#_____

Group/Acct#_____ Group/Acct#_____

Subscriber_____ Subscriber_____

Subscriber Date of Birth _____ Subscriber Date of Birth_____

Client's relationship to Subscriber Client's relationship to Subscriber

__Self __Spouse __Child __Other_____ __Self __Spouse __Child __Other_____

**Referral Source**

How did you hear of this office clinic (or from whom)?_____

**Pat Fogle (NPI 1790752319)** _____ **Carol Gindratt (NPI 1518018761)** _____
**Carl McQueen (NPI 1457447823)** _____ **Cynthia Young (NPI 1326142449)** _____
**Sarah St. Cyr (NPI 1871852947)** _____

# CLIENT INTAKE FORM

(Please print clearly)

**Client NAME**_____ **Appt Date/Time** _____

**Client DOB** _____ **SSN**_____ **Email**_____

**Client Phone: Home**_____ **Work**_____ **Cell**_____

**Client Address**_____**City**_____**ZIP**_____

**Parent or Legal Guardian Name**_____**Phone**_____

**PRIMARY INSURANCE COMPANY**_____ **Phone**_____

**Group or Plan #**_____ **Insurance ID#**_____

**Insured Name**_____**DOB**_____ **SSN**_____

**Relationship to Client**_____ **Employer**_____

**Insured Address**_____

**SECONDARY INSURANCE? YES NO If YES, 2nd Ins**_____**ID#**_____
(CIRCLE ONE)

# ASSIGNMENT AND RELEASE

**I HEREBY AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO PROVIDER OF SERVICE. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO GIVE MY PERMISSION FOR RELEASE OF MEDICAL RECORDS INFORMATION FOR FILING OF MY INSURANCE.**

_____

**CLIENT SIGNATURE (Parent or Legal Guardian if Minor)** **DATE**

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**INSURANCE VERIFICATION FOR OFFICE USE ONLY**

Date Verified: _____ _ By: _____ Spoke with: _____

Coverage: _____ Co-Pay: _____

Deductible: _____ Amount Met: _____

Pre-Certification # : _____ Visits: **90791**: **90834**: **90837:** No Limitation

Dates Covered: _____ TO: _____ **Network** **Non-Network**
Starting Ending Circle One

Family Therapy (**90847**) Covered: Yes No (Circle One)
Pre-existing Wait: Yes No (If yes, end date: _____)
Claims Mailing Address (Ask if mental health is handled by another organization):

# FREEDOM COUNSELING

**Carol Gindratt MEd, LPC**
**1219 E. South 11th, Suite A**
**Abilene, Texas 79602**
**(325) 676-2039**

## PROFESSIONAL DISCLOSURE STATEMENT

**Nature of Counseling:** My approach to counseling is eclectic and based on the needs of each individual. We will work together to develop your personal goals and I will offer you more effective ways to deal with your interpersonal problems I believe that all of your behaviors are meaningful and I will help you develop insight into the reasons behind your actions so that you may understand them and move forward to change them. By doing so, we can work to develop any destructive thoughts and behaviors into more productive ones. You may be discouraged in areas of your life such as work, school, or relationships. I will encourage you to take steps to make changes in your life in order to reach your goals successfully in these areas. I believe that you are a creative, goal-oriented individual who can take responsibility for the direction of your own life. Primarily, we will focus on what is happening currently in your life, however, we may explore your past in order for us to gain insight into your current approaches to life.

## INFORMED CONSENT

**Counseling Relationship:** Typically sessions are conducted with clients one time weekly for approximately 45-60 minutes. During our session time I will strive to establish a trusting and honest relationship to help foster your growth and health. I will endeavor to provide a safe, comfortable atmosphere in sessions, focusing my energy on you and your concerns. I ask that you come prepared to work during sessions, allowing yourself the best opportunity for help. Furthermore, I ask that discussions of your issues be limited to office sessions, where I can best focus my energy on you. Public contact, social gatherings, etc. are not good times for me to counsel with you. We will both be better served if we save these conversations for our sessions.

**Effects of Counseling:** At any time, you may initiate a discussion of possible positive or negative effects of entering, continuing, or discontinuing counseling. I will strive to ensure that all efforts are directed towards helping you realize your desired outcome. There are no guarantees of outcome or effectiveness of counseling.

**Costs and Reimbursements: The usual fee for the first session is $150.00, after which the basic fee for other sessions is $135.00 for 60 minutes. Longer or shorter sessions are prorated from this basic fee. Unless previous arrangements are made, payment is expected at time of service.** Many times insurance will cover part or all of the fees. Additionally, I am on the panel of many insurance providers. Please ask me about your insurance or payment options and plans upon arrival.

**Emergency Contacts:** On rare occasions emergency contact is necessary due to the nature of the ongoing condition. I do maintain an emergency number, which is provided on an as-needed basis.

**Court Appearance:** I will make arrangements to offer testimony in court proceedings. The fee for this service is $200.00/hour, with a 5-hour minimum. If travel is required, mileage charges will be added at the rate of $.50/mile plus a $50.00 per day per diem. Minimum payment for this service is expected at least 1 week PRIOR to the scheduled date. I cannot guarantee refunds or credits in cases of date changes due to the major scheduling conflicts involved.

**Cancellations: In order to properly serve all clients, I maintain a tight schedule. Cancellation is expected at least 24 hours in advance. Failure to cancel or missing an appointment will result in a billed No Show, which is half the standard hourly fee. Insurance will not reimburse this charge.**

**Confidentiality and Records:** All of our communication becomes part of the clinical record. Records will remain my property. Adult client records are disposed of seven years after the file is closed. Minor clients' records are disposed of seven years after the client's 18th birthday. Most of our communication is confidential, but the following limitations and exceptions do exist: a) I determine that you are a danger to yourself or someone else; b) you disclose abuse, neglect, or exploitation of a child, elderly, or disabled person; c) I am ordered by a court to disclose information; d) you authorize me to release your records with your signature; e) I am otherwise required by law to disclose information. Based on recent HIPPA legislation, you are entitled to review the information being released to your insurance provider and approve/deny its transfer. Please note that in cases where the insurance provider refuses compensation, you will be responsible for payment. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first. In the case of marriage or family counseling, I will keep confidentiality (within limits cite above) anything you disclose to me without your family knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to the therapeutic progress. Copy cost for records is $2.00 per page, payable upon receipt.

By your signature below, you are indicating that you read and understand this statement and all the information presented in it, and that any questions you had about this statement were answered to your satisfaction. By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to each of it specifications.

| _____ | _____ | _____ |
|---|---|---|
| Client Signature/Minor's Legal Representative | Printed Name | Date |

# Privacy of Information Policies

**This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.**

## Our Legal Duties

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

## Use of Information

Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

## Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

## Public Safety

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

## Abuse

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 health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

## Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

## In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

## Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

## Judicial or Administrative Proceedings

Health care professionals are required to release records of clients when a court order has been placed.

## Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

## Other Provisions

When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to

credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within this office or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the office or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the office (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

## Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $_2.00____ per page, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

Your have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

## Complaints

If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Texas State Board of Examiners for Licensed Professional Counselors at (512)834-6658____. If you file a complaint we will not retaliate in any way.

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Direct all correspondence to:
Carol Gindratt
1219 E. South 11th, Suite A
Abilene, Texas 79602 (325)676-2039

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**I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.**

Client's name (please print): _____

Signature: _____ Date: _____/_____/_____

Signed by: __client __guardian __personal representative