206 S. Kentucky St. Suite 102
McKinney, TX 75069

Phone: 214.945.3979
www.woodruffcounseling.com

CLIENT INFORMATION

Today's Date: _____

Client Name_____Spouse Name _____

Date of Birth: _____ Age: _____ Sex (please circle): M F

Home Address _____

City_____State_____Zip _____

Home Phone ( ) _____ Cell ( ) _____

Work Phone: ( ) _____

Primary email address _____

Secondary email address _____

Please check any of the following at which you prefer to be contacted or receive written material:
___Work Phone ____Cell Phone _____Primary email _____Secondary email _____Home Address

_____ **I grant permission to leave voice mail messages on the phone number(s) selected above.**

Emergency contact name and phone # _____

_____ **I grant permission to contact the above emergency contact should the counselor deem it necessary in regard to my mental and/or physical safety and care.**

Highest level of education:_____Degree(s): _____

Occupation _____ Employer _____

Marital Status (please circle): Married (Years____) Separated Divorced Widowed

Single Single in Relationship Single but Engagement

If Married, Children with Current Spouse (names/ages) : _____

_____

Previous Marriage(s): First (Duration____) Second (Duration ___) Third (Duration ___) Fourth (Duration_____)

Children by Previous Marriage(s) (names/ages): _____

_____

Immediate Family Members (spouse, children)			*Family of Origin* (parents, siblings)		
Name	Age	Relationship	Name	Age	Relationship

PHYSICAL HEALTH

Primary Care Physician: Name _____

Address_____Phone _____

General Physical Health (please rate yourself):

Very good Good Average Poor Improving Declining

If not very good, please explain:_____

_____

_____

List all illnesses, allergies, injuries or handicaps that presently affect you.

_____

_____

Medications: Please list any medications and dosage you are currently taking.

1._____ Purpose: _____
2._____ Purpose: _____
3._____ Purpose: _____
4._____ Purpose: _____

MENTAL HEALTH

Are you currently under the care of another mental health or counseling professional? YES NO

If the answer is "yes," you may be asked by me to sign a Consent to Disclose document, which allows for communication between counselors, in order to inform and consult with one another in the best interest of your treatment.

If yes, please indicate the name and contact information:

Name of Professional _____

Address _____Phone number_____

Dates of Service: from_____/_____to_____/_____

Reason(s) for provided care _____
_____

Have you ever been hospitalized for mental health concerns? YES NO (Circle One)

If yes, please explain briefly (include hospital, doctor's name and dates): _____

_____

_____

_____

Past/current suicidal or homicidal thoughts/attempts? Please explain briefly.

_____

_____

_____

Physical/sexual abuse? Please explain briefly.

_____

_____

_____

CHURCH AFFILIATION

1. Are you a member of a local church? YES NO (Circle One)
2. If so, what is the name and location of the church?

   _____
3. If so, how long have you attended this church? _____
4. Are you actively involved in your church? YES NO (Circle One)
5. Do you have a person/people to whom you are accountable at your church? YES NO (Circle One)
6. Do you believe being an active part of a community of believers is important to reaching your goals in counseling? Why? Why Not?_____

   _____
7. Religious Affiliation as a Child:_____As an Adult: _____

REFERRALS

Please provide the information below regarding who referred you to John Woodruff Counseling.

Name: _____ Address: _____

Email: _____ Phone: _____

Church/Ministry Affiliation: _____

May I send them a card extending my appreciation for their trust in my services? YES NO (Circle One)
The note will be a general thank you note and NO information will be given, including name, etc.

PRELIMINARY SELF-ASSESSMENT

Please check **ALL** the following that apply to you at this time:

- ☐ Abuse (physical, emotional, sexual)
- ☐ Abuse of non-prescription drugs
- ☐ Adjustment to life changes (job change, move, marriage)
- ☐ Anger
- ☐ Anxious (nervous, clingy, fearful, worried)
- ☐ Behavior problems
- ☐ Being a parent
- ☐ Binge/Vomit/Laxatives
- ☐ Blackouts or temporary loss of memory
- ☐ Bowel disturbances
- ☐ Career choices
- ☐ Children having problems
- ☐ Compulsive behavior
- ☐ Crying spells
- ☐ Depressed
- ☐ Difficulty having fun
- ☐ Difficulty making friends
- ☐ Disturbing memories (past abuse, neglect or other)
- ☐ Divorce
- ☐ Dizziness
- ☐ Drugs
- ☐ Easily distracted
- ☐ Education
- ☐ Excessive boredom
- ☐ Fainting spells
- ☐ Family or Step-family relationships
- ☐ Fatigue
- ☐ Feel lonely
- ☐ Feel panicky
- ☐ Feeling "numb" or cut off from emotions
- ☐ Feeling "on top of the world"
- ☐ Feeling ashamed
- ☐ Feeling distant from God
- ☐ Feeling fat
- ☐ Feeling guilt
- ☐ Feeling of inferiority
- ☐ Financial problems
- ☐ Health concerns
- ☐ Hearing voices
- ☐ Hyperactive
- ☐ Inability to control thoughts
- ☐ Insomnia (unable to sleep)
- ☐ Lack of motivation
- ☐ Learning/Academic difficulties
- ☐ Legal matters
- ☐ Lose time
- ☐ Loss of interest in sex
- ☐ Memory
- ☐ Nightmares
- ☐ No appetite
- ☐ Non-family relationship problems
- ☐ Palpitations
- ☐ Parent/child relationship problems
- ☐ Poor home environment
- ☐ Problem with alcohol
- ☐ Religious/Spiritual concerns
- ☐ Self-control
- ☐ Sexual identity concerns
- ☐ Sexual problems
- ☐ Sleeping all the time
- ☐ Spouse problems
- ☐ Suicidal urges
- ☐ Suspicious of other people
- ☐ Take sedatives
- ☐ Tense feelings
- ☐ Thoughts of suicide
- ☐ Tremors
- ☐ Unable to relax
- ☐ Unable to sit still
- ☐ Other _____

PRELIMINARY SELF-ASSESSMENT (continued)

1. Briefly describe why you have chosen to seek counseling at this time from this counselor.

2. What do you hope to achieve throughout the counseling process?

3. Have you had counseling in the past? From whom? For what reasons? What were the outcomes?

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DISCLOSURE AND CONSENT FORM

COUNSELOR CREDENTIALS AND LICENSURE

John Woodruff, M.A., LPC, holds a license in the State of Texas to provide counseling services. I am also a Registered Play Therapist (RPT). Under this license, I practices under the authority of the Texas LPC licensing board, and therefore must adhere to the board's ethical guidelines.

METHOD OF COUNSELING

It is my desire to see the problem that brought you into counseling resolved to your satisfaction. As a Biblical counselor I base my counseling on biblical truth and principles. Ialso desire that you will grow in your ability to experience deep joy and love others in a powerful way. To reach these goals, I will need to get to know you, how you view your problem, and how you relate to significant people in your life. Because I believe God has built us to be involved in and enjoy relationships with Him and others, we will pay attention to the relationships in your life as we work through the problems you have identified.

RESPONSIBILITIES AS YOUR COUNSELOR

I believe that all aspects of a person are important and as such will consider spiritual, psychological, social, and biological factors when working with you. I desire that the therapeutic relationship be mutually respectful, supportive, and challenging in an effort to help you reach your stated goals. Change is difficult and the process of change can sometimes introduce discomfort. Remembering and resolving unpleasant events can arouse fear, anger, depression, or other emotions that may feel foreign, but are a normal part of the growth process. Questions about the counseling process are always welcome. I desire and expect that you will benefit from this professional relationship but I cannot guarantee specific results.

I am responsible to be honest with you and to keep careful, confidential records concerning the directions being pursued in the counseling process. I will follow a course of counseling that is in your best interest and will attempt to resolve only those problems, which are within the scope of my training.

Certain problems brought into counseling may have (or develop) physical components. In such cases, I will advise medical consultation.

FEES and INSURANCE

The standard fee for individual, couple, or family counseling is **$120.00 per 50-minute session,** unless otherwise agreed upon. Payment is expected at the beginning of each counseling session by personal check, cash or credit. I have the right to withhold further counseling if you do not financially meet the obligation of payment as cited above. As returned checks create an administrative cost, there will be a $15.00 fee for any returned check.

I do not verify insurance coverage, file insurance claims nor receive insurance payments, but will provide appropriate documentation in order to self-file with your insurance company. Client are responsible for verifying their coverage and eligibility should they decide to file a claim for reimbursement. I will provide a receipt to substantiate payment of each session fee. The receipt will include a diagnosis, if warranted, and may be used to support claims for reimbursement. Clients are responsible for ensuring that the requirements for their claim submission are complete.

CANCELLATION POLICY

In the event you are unable to keep an appointment, 24-hour advance notice of your cancellation is required. Except for emergencies such as illness or an accident, you will be charged full fee for a "no show" or for a cancellation without a 24-hour notice.

STATEMENT OF CONFIDENTIALITY

Counseling will adhere to very strict confidentiality standards. Client information is managed using procedures designed to protect the privacy and security of personal data. Counseling records are strictly confidential, except as noted in the provided document "Right to Privacy" and the section below entitled "Client Records and Release of Records". In order to protect your right to confidentiality, your written authorization is required if you desire that information be shared by us about your counseling to another person or agency.

In the case of couples (any form of a dyad relationship, including friendship, pre-marital, marriage, etc.), or family counseling, there is limited confidentiality, ***meaning that confidentiality belongs to the relationship and not to the individual***. When expedient the counselor will share with the counselee the intent to notify relatives or authorities before the above actions are taken.

CONFIDENTIALITY AND MARRIAGE COUNSELING

If you enter therapy as a married couple, it is important that you understand that you, as a couple, are my client. As such it is standard practice to see both husband and wife together as much as possible so that any and all issues, concerns, personal information, and behavioral patterns may be disclosed (or have the opportunity to be disclosed) in the presence of each other, as well as in my presence.

If, in the course of therapy, either of you request an individual session, I will ask that the following conditions be in place:

1. Your spouse is aware of your desire to have an individual session and has the opportunity to respond to this request.
2. Individual sessions will be added as needed to benefit you as a couple but are not the "norm" for therapy, replacing sessions as a couple.
3. Individual sessions, even if beneficial to you on one hand, do not become a hindrance to your overall ability to take hold of, organize, and manage your own personal growth while in the presence of your spouse.

LIMITS OF CONFIDENTIALITY FOR MARRIAGE COUNSELING

If therapy is started as a married couple and one spouse chooses to disclose secret, personal information (such as an affair, some pattern of sexual acting out or mismanagement of finances) in an individual session, that information will be held in confidence between the spouse and me with the following provisions:

1. Ramifications of the disclosed information will be examined.
2. Ramification of the potential disclosure of that information to your spouse will be examined.
3. We will work to clarify your personal options as to what to do with the disclosed information in relationship to the marriage.
4. You will be encouraged to take personal responsibility and proceed with integrity as this information is processed and applied to the growth process of the marriage.

Because I believe that marriages cannot thrive when secrets are present, I will ask that information pertinent to the health of the marriage be disclosed to the spouse in a timely manner. If a spouse is not willing to do this and the withholding of this information creates a block in the process of marriage counseling I may suggest termination of the counseling. If this becomes the case I will clearly and responsibly communicate this to you with discussion. If I feel I can no longer be of help to you as a couple (the couple being the client) I will offer options for either individual or marriage counseling elsewhere.

Because you, as a couple, are the client, please note that in the unfortunate event of a divorce, I will not be in a position to testify or serve as a witness for either one of you against the other.

CLIENT RECORDS AND RELEASE OF INFORMATION

All communication between the client and counselor becomes part of the clinical record. Records are the property of John Woodruff Counseling. In the event of my death or incapacitation, or I close my practice, your file will be retained by Teri Mills-Manuel, LPC (214) 585-4859. In accordance with legal requirements, adult client records may be disposed of five years after the file is closed; minor client records are disposed of seven years after the client's 18th birthday.

In the case of marriage, couples, or family counseling, there is limited confidentiality, ***meaning that confidentiality belongs to the relationship and not to the individual***. Therefore, the clinical record belongs to the relationship, not to the individual.

While most communication between a client and counselor is confidential, the following limitations and expectations do exist:

- **With Written Consent**

A client may request that specific information be sent to another individual. Prior to a disclosure, the client must sign a "Consent for Release of Information" document. Information will not be released for reasons unrelated to treatment.

In the event that the client is a relationship, rather than an individual, written consent must be obtained by all parties in the relationship prior to release of information.

- **Without Written Consent**

Client information may be released without consent in the following situations:

1. I may consult with other professionals to gain other perspectives and ideas on how to best help you reach your goals. This type of consultation is obtained in a way that maintains complete confidentiality. I do this in order to provide the highest possible standard of care.

2. If a court of law orders a subpoena of case records or testimony I will first assert "privilege" (which is your right to deny the release of your records). I will release records with your written permission or if a court denies the assertion of privilege and orders the release of records.

3. If I feel you are a threat to yourself or others (suicidal or homicidal) I will need to report this to appropriate family members, law enforcement professionals and/or mental health professionals.

4. There are a broad range of events that are reportable under child protection statutes. Suspicion of physical or sexual abuse of a child will be reported to Child Protective Services. When the victim of child abuse is over 18, I am not legally mandated to report this unless there is reason to believe there are minors still living with the abuser who may be in danger of being abused.

5. If I become aware of abusive, neglectful, or exploitive behavior toward an elderly or disabled person I will be required to report this to the appropriate authorities.

6. If your insurance company requests information, in order to process his or her claim for reimbursement.

POLICY REGARDING LEGAL MATTERS

I do not testify in court. In most cases, clients are discouraged from having me subpoenaed or having me provide records for the purpose of litigation. Because I can only provide a testimony that conforms to the facts of the case in accordance to our professional opinion, it could mean that such testimony will not necessarily be in the client's favor. With this in mind, **clients seeking records or testimony will be financially responsible for fees for services rendered, regardless of the content and implications of the records and/or testimony.** In the case of marriage or couples counseling, in which individuals are seen separately as well as together, an obvious conflict of interest is present when records and/or testimony is sought against the other or is in favor of one over the other. Therefore, mutual consent from both parties would be necessary for release of information or when testimony is sought. This is in the interest of the maintenance of trust, which is of utmost importance in counseling relationships with clients.

If I am to receive a subpoena (for records or testimony), the attorney (or his or her office staff) will need to call and set up a time for the subpoena to be served during business hours. I request a minimum of 72 hours notice of any court appearance so that schedule changes for my clients can be made within a reasonable time frame.

Please note: If a subpoena or notice to meet with attorney(s) is received without a minimum of 48 hours, there will be an additional $250 express charge.

When a signed authorization to release form is included with the subpoena, the counselor will release ***only the relevant and the minimum necessary information***, unless otherwise ordered by the court. This includes disclosure of confidential information regarding family members who were part of family therapy or other people in the client's life who were discussed in therapy or who attended one or two sessions. The counselor may discuss with the client any issues that he or she believes may be clinically or legally damaging to the client and maintains the right to withhold the release of such information that is deemed as potentially damaging. In some situations, the counselor may offer to provide a summary of the records rather than producing the entire records.

When it comes to court action, the following fees are in effect even if the subpoena is sent from the opposing side of the case and even if our ongoing relationship has ended:

1. Preparation Time (including the copying of records, submission of records, and writing summary reports): $210/hr
2. Record copying fees are $.50 per page
3. Phone Calls: $210/hr

4. Depositions: $250/hr
5. Time Required in Giving Testimony: $250/hr
6. Travel Expense: $.55 mile (plus the actual cost of meals and lodging, if needed).
7. Time Away from Office Due to Deposition or Testimony: $210/hr
8. All attorney fees and costs incurred by the therapist as a result of legal action.
9. Filing Documents with the Court: $100 per document plus any fees incurred for filing
10. The minimum charge for a court appearance: $2000

A non-refundable retainer of $2000 is due at least 72 business hours before the scheduled court appearance. The remainder of the costs will be billed after the court appearance and will be due upon receipt. If the therapist is subpoenaed and the case is reset with less than 72 business hours notice prior to the beginning of the day of the scheduled subpoena, trial, and/or the testimony, then the client will be charged $500 (in addition to the original retainer of $2000 to appear in court).

All fees listed above are doubled if the therapist is scheduled to be going out of town.

Bills are presented to clients on a weekly basis and payment is due upon receipt. If payment is not made within a week of date of the invoice, the client agrees to a 15% surcharge to be added to the balance. A zero balance will need to be kept at all times.

You are responsible for any legal fees that I incur as related to your case or treatment.

CLIENT'S RIGHTS AND RESPONSIBILITIES

The course of therapy is determined mutually by me, the counselor, and you, the client. You are encouraged to freely ask me any questions you have regarding my educational and professional background, therapeutic approach, and the specific therapy plan and progress.

People often ask how long they will be in counseling. Some clients need fairly brief therapy to understand their conflicts and reach the goals they set for themselves. Others may require many months or even years of work to achieve the growth they desire. However, whether your program of therapy is brief or long, the best results in therapy are often obtained by those who attend sessions on a regular basis. I attempt to work with people in such a way that they have sufficient time to meet their individual therapy goals but I discourage clients becoming inappropriately dependent upon therapy. Consequently, treatment duration varies from person to person. Clients typically know when they are beginning to "feel finished" with therapy work and I encourage you to discuss this when it happens for you so that we can close our relationship as carefully as we begin it. Please keep in mind that the best results in therapy are often obtained by those who attend sessions on a regular basis.

State certification requirements for professional counselors do not imply the effectiveness of any treatment. It is your responsibility to determine whether the services offered are appropriate and ultimately helpful.

It is always my intention to provide services in a professional manner that is consistent with all accepted ethical standards. If at any time in the course of our work together you feel that there may have been a misunderstanding or you have any question or complaint about my services, please bring this up with me immediately so that I can become aware of your concern and resolve the matter with you. I am required to abide by the rules set forth by the Texas State Board of Examiners of Professional Counselors. These rules include guidelines for counseling methods and practices as well as professional ethical standards.

You have the right to report violations to:

Texas State Board of Examiners of Professional Counselors
1100 West 49th Street
Austin, Texas, 78756-3183
(512-834-6658)

You have the right to end therapy at any time without any moral or legal obligations. Financial obligations will be only those already accrued. If you choose to end the counseling relationship, I ask that you participate in a termination session.

EMAIL AND PHONE CONSULTATIONS

I do not provide counseling via email. All email correspondence with me should be kept to a minimum and will not involve the giving of advice or counsel or to address sensitive issues. I do not monitor email continuously; so the most effective way to reach me is via phone. **I**f required, time spent by your counselor in the sending or responding to emails or in phone conversations when exceeding more than 15 minutes will be billable for a minimum of one half hour with payment due at the next counseling appointment.

EMAIL IS NOT RECOMMENDED AS A METHOD FOR CONTACTING ME IN AN EMERGENCY.

EMERGENCIES:

John Woodruff Counseling is not a crisis response center. Emergencies should be directed to appropriate agencies that provide emergencies services. In the event of what appears to the client as an emergency, he or she should contact a physician, a local emergency room, or the local police department when necessary and appropriate (dialing 911). It is the client's responsibility to seek the appropriate resources in emergency situations.

Your counselor may contact the emergency contact provided by the client on his or her intake information, should the counselor deem it necessary in regard to the client's mental and/or physical safety and care.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect July 1, 2016, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make a new Notice available upon request.

USES & DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

1. We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes. To help clarify these terms, here are some definitions:

    - "*PHI"* refers to information in your health record that could identify you.
    - *"Treatment, Payment and Health Care Operations"*
        - *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 other practitioner.
        - *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.
        - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
    - "*Use*" applies only to activities within John Woodruff Counseling, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
    - "*Disclosure*" applies to activities outside of John Woodruff Counseling, such as releasing, transferring, or providing access to information about you to other parties.

2. We may disclose to a family member, other relative, a close personal friend of yours, or any other person identified by you, the health information directly relevant to such person's involvement with your care or payment related to your health care.

3. **Contacting You.** We may use and disclose health information to reach you about appointments and other matters. We may contact you by mail, telephone or email. We may leave voice messages at the telephone number you provide us with, and we may respond to your email address.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission that is 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 and 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 counseling notes. *"Counseling 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 counseling 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, and the law provides the insurer the right to contest the claim under the policy.

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 cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.

Adult and Domestic Abuse: If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Texas Department of Protective and Regulatory Services.

Health Oversight: If a complaint is filed against us with the State Board of Examiners, the board has the authority to subpoena confidential mental health information from us relevant to that complaint.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case**.**

Serious Threat to Health or Safety: If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.

Worker's Compensation: If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

Health-Related Services. We may use and disclose health information about you to send you mailings about health-related products and services available John Woodruff Counseling.

PATIENT RIGHTS

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request. You may revoke the authorization, in writing, at any time, but we cannot take back any uses or disclosures of your health information already made with your authorization.

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.

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. 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 a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a paper copy of this Notice at any of our facilities or by calling 214.945.3979. You may view this Notice at our Web site, http://www.woodruffcounseling.com

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. 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 for which you have neither provided consent nor authorization (as described previously). On your request, we will discuss with you the details of the accounting process.

CHANGES TO THIS NOTICE

John Woodruff Counseling may change this Notice at any time. Any change in the Notice could apply to medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current Notice at each of our facilities and on our Web site, www.woodruffcounseling.com. The effective date of the Notice is on the first page in the top right corner.

QUESTIONS OR COMPLAINTS

For more information about our privacy policy or have questions or concerns, please contact us. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may complain to us using the contact information listed at the end of this Notice. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will provide you with that address to file your complaint upon request.

Contact: John Woodruff
Telephone: 214.945.3979
Address: 206 S. Kentucky St. Suite 102
McKinney, TX 75069

john woodruff
COUNSELING

ACKNOWLEDGEMENT

I acknowledge that I understand and agree with the following:

FEES AND CANCELLATION POLICY:

1. Fees for all services are due at the time of my appointment by cash, check, or credit card (when available), unless other arrangements have been previously agreed upon.
2. If I do not give 24-hour advance notice for a missed appointment, I am responsible for paying the full amount of the session.

Initials: _____

INSURANCE RELEASE:

I authorize my counselor to give out psychological information that is needed by my insurance company. This authorization for release is valid for the duration of the therapeutic relationship. I understand and agree that a diagnosis must be given and that the diagnosis will become a part of my insurance records.

Initials: _____

LEGAL POLICY AND COURT FEES:

I have read and understand the legal policy and fees stated I in this document. I understand if I seek records or testimony then I will be financially responsible for any and all fees for services rendered, regardless of the content and implications of the records and/or testimony.

Initials: _____

COPY OF DISCLOSURE AND CONSENT (please sign *both* copies):

By signing this disclosure and consent statement, the client acknowledges having been informed of his/her rights and responsibilities under regulatory laws for counselors in Texas. In addition, the client acknowledges he/she has read and understands the administrative policies for this counseling office.

_____ _____

Signature of client Date

_____ _____

Signature of Spouse/Guardian Date

_____ _____

Signature of Counselor/Therapist Date

ACKNOWLEDGEMENT

I acknowledge that I understand and agree with the following:

FEES AND CANCELLATION POLICY:

1. Fees for all services are due at the time of my appointment by cash, check, or credit card (when available), unless other arrangements have been previously agreed upon.
2. If I do not give 24-hour advance notice for a missed appointment, I am responsible for paying the full amount of the session.

Initials: _____

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I authorize my counselor to give out psychological information that is needed by my insurance company. This authorization for release is valid for the duration of the therapeutic relationship. I understand and agree that a diagnosis must be given and that the diagnosis will become a part of my insurance records.

Initials: _____

LEGAL POLICY AND COURT FEES:

I have read and understand the legal policy and fees stated I in this document. I understand if I seek records or testimony then I will be financially responsible for any and all fees for services rendered, regardless of the content and implications of the records and/or testimony.

Initials: _____

COPY OF DISCLOSURE AND CONSENT (please sign *both* copies):

By signing this disclosure and consent statement, the client acknowledges having been informed of his/her rights and responsibilities under regulatory laws for counselors in Texas. In addition, the client acknowledges he/she has read and understands the administrative policies for this counseling office.

_____ _____

Signature of client Date

_____ _____

Signature of Spouse/Guardian Date

_____ _____

Signature of Counselor/Therapist Date

(Client's Copy)