Cary Scott Counseling
A NEW DAY, A NEW EXPERIENCE, A NEW BEGINNING

972.325.5942 phone
cary@caryscottcounseling.com
www.caryscottcounseling.com

6750 Hillcrest Plaza Dr. Ste. 304 Dallas, TX 75230
4037 North Goliad Ste. 115, Rockwall, TX 75087

PATIENT INFORMATION

If services are for a couple or family, please fill out according to whose first name you want on receipts.

Name: _____ Date: _____

Social Security #: _____ Driver's License #: _____

Home address: _____ Email Address: _____

City/State/Zip: _____ Date of birth: _____

Phone: Home: _____ Mobile: _____

__ Single __ Married __ Divorced __ Living Together __Widowed Sex: ___M ___F Age: _____

Employed by: _____ Occupation: _____

Spouse: _____ Employed by: _____

Spouse's Email: _____ Occupation: _____

Emergency contact name: _____ Contact's #: _____

Family MD/Psychiatrist: _____ Contact's #: _____

RESPONSIBLE PARTY

Name: _____ Relationship to client: _____

Address: _____ Home phone: _____

City/State/Zip: _____ Bus. Phone: _____

Employed by: _____ Email: _____

How did you find me? (Please circle and be specific) FRIEND DR. REFERRAL INTERNET SEARCH

PSYCHOLOGY TODAY _____

OTHER: AND/OR NAME OF REFERRAL SOURCE

Insurance Information

By providing the following information you are giving consent to disclose your personal health information to the insurance company identified.

Insurance Co.: _____ Member ID: _____

Primary Name: _____ Group #: _____

Primary DOB: _____ Behavioral Health Deductible: _____ Deductible Met: ___Y ___N

Contact number for providers: _____ EAP/Pre- Authorization#: _____

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Patient Information & Consent to Treatment

Welcome! I look forward to working with you regarding the concerns that brought you here. Please read carefully the following information concerning our professional services and business policies, and discuss with your therapist any questions you may have. I will also go over this consent verbally. Your signature at the end of this document indicates you have read and understand this information, thus providing an agreement for proceeding with treatment.

Qualifications: Cary Scott is a licensed professional counselor, certified school counselor, certified trauma model therapist through the Ross Institute and has extensive experience in psychiatric hospital acute care treatment. I am certified in trauma model therapy through the Ross Institute and I have extensive experience in psychiatric hospitals as a mental health therapist.

Orientation: Cary Scott is trained in a variety of approaches to therapy, including cognitive-behavioral, family systems and family of origin approaches, and solution-oriented, short-term therapy. I employ a variety of techniques to assist you in clarifying your goals for change and taking steps in the desired direction. The overall goal in therapy is to assist you in being as healthy as possible physically, mentally, emotionally, relationally, and spiritually. All people are created with a need for purpose and meaning, a need for significant connection with others, and a capacity for growth. Thus there is a strong commitment to providing quality psychological care to assist you in achieving these goals.

Nature of Psychological Services: The purpose of psychological treatment may include relieving distress; decreasing symptoms of a mental or emotional disorder; improving one's mood, self-esteem, or overall well-being; working through trauma or loss; working to improve significant relationships; or learning better coping skills for life's challenges. As such, psychotherapy is not an exact science and it is not like a visit to a medical doctor, but rather requires your active participation in identifying problems and goals, and working to make changes. Your therapist will work to create a safe setting in which you feel respected and accepted in order for you to openly discuss issues which may be at times personal and uncomfortable. Your therapist will be sensitive to the pacing and timing of these discussions to maximize a therapeutic result.

Therapy Relationship: Sessions are usually 45-50 minutes on a weekly basis. Less frequent sessions will be scheduled as improvements occur, goals are met, and you near the end of treatment. Feel free to express your preferences for scheduling of sessions, as your needs will likely change over the course of therapy. While psychotherapy often addresses very personal issues, for your work to be therapeutic the relationship between you and your therapist must be a professional relationship rather than a social one. Personal and/or business relationships undermine the effectiveness of therapy. Payment for services rendered is the only remuneration that is expected. Contact with your therapist will be limited to sessions you schedule at our office. Your therapist will not accept friend requests on social networking sites. Emergency phone calls after hours will be handled as follows: if it is life-threatening, you will be directed to call 911 or go to your nearest emergency room. Crisis management calls will be brief and aimed at stabilizing the situation for processing at your next scheduled appointment. Any phone calls lasting more than 10 minutes will be charged per minute at your regular session rate. For example: if your regular session fee is $100/per a session, a call lasting 15 minutes will be charged $25.00. $100/60 minutes = $1.67. 15 minutes x $1.67 = $25.00. This same pricing structure will be used for email correspondence. For your protection, we advise emails to be limited to dealing with typical office matters such as scheduling or billing questions. Email is not a secure form of communication and your confidentiality cannot be guaranteed. All other matters should be discussed during your session time.

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Effects of Therapy: Psychotherapy can have benefits and risks. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. However I cannot guarantee your specific results. Progress depends on many factors including motivation, effort, and how well you work with your therapist as a team. Additionally, therapy at times involves unpleasant feelings and addressing issues that initially may be difficult, even painful. The changes you make may impact your relationships, your functioning on the job or at home, or your understanding of yourself. Some of these changes may be temporarily distressing. Whenever possible, your therapist will anticipate these risks and discuss them with you throughout the course of therapy. I am committed to working with you to achieve the best possible results for you.

Patient Rights: Some individuals only need a few sessions to achieve their goals; others may require months or even longer. Your first 1-3 sessions will involve an evaluation of your needs and goals. Your therapist will then offer you some initial impressions of what your work will include and make recommendations regarding a treatment plan. Your active involvement in this plan, along with your opinion of what you need and whether you feel comfortable working with your therapist are crucial to your success in therapy. You have the right to discontinue your professional relationship with your therapist at any time, though it is recommended you schedule a termination session for reaching closure. You also have the right to refuse any recommendations your therapist makes. If your refusal compromises your therapist's ability to render services in an ethical or beneficial manner (e.g. refusal to make a safety contract when feeling suicidal), your therapist may determine to discontinue treatment. In such cases, you will be provided with referrals to another competent mental health professional, if you desire.

Services will be rendered in a professional manner consistent with the legal and ethical standards established by the Texas state licensing board for Professional Counselors. If at any time or for any reason you are dissatisfied with our services, please let your therapist know.

If you are still unsatisfied, you may report your complaints to the Texas State Board of Examiners of Professional Counselors at 1-800-252-8154.

Referrals: Throughout the course of therapy, your therapist may be making recommendations concerning treatment, some of which may involve alternative treatment options we do not provide, e.g. hypnotherapy, medication evaluations, inpatient or intensive outpatient treatment, to name a few. If at any time you or your therapist believes a referral is needed, you will be provided recommendations for other providers or programs to assist you. Alternative treatment options and/or adjuncts to therapy may also be discussed at your request (e.g. support groups, community services). You will be responsible for contacting and evaluating those referrals or alternatives.

Fees and Payment: Cary Scott charges $120.00/50 minute session. Sessions may be scheduled for more or less than 50 minutes and will be billed in proportion to the hourly rate. Payment is expected at the time services are rendered. I request you keep a credit card authorization form on file for billing purposes. If you wish to pay by personal check or with cash, you may do so but we still need a credit card number on file to bill for no show or late cancellations. If payment becomes a hardship for you, please discuss this with your therapist so a suitable payment plan can be arranged for you. Other services for which additional fees may apply include: telephone calls, clinical consultations with other providers that you give consent for your therapist to speak with;

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preparation of treatment summaries or treatment plans, letters or documents for employment, disability, or legal purposes; and photocopying and/or mailing of medical records to you, to another provider, attorneys, or insurance companies.
For legal proceedings that require your therapist's response, we bill $350 per hour (includes time spent responding to subpoenas, depositions, time spent waiting to testify, driving time to the court, etc.). Payment will be expected from you, regardless of whose attorney subpoenas my involvement. Patient records will not be released without written consent, unless court ordered to do so. **Please note:** a subpoena does not constitute a court order.

Cancellation Policy: If you are unable to keep a scheduled appointment or need to change an appointment, please notify our office as soon as possible. Appointments not kept or cancelled less than 24 hours in advance will be billed for the time scheduled at your regular session rate.

Records and Confidentiality: All records may legally be disposed of five years after the file is closed.
Trust and openness are essential for effective therapy. Our communications over the course of therapy become part of your protected health information, recorded in your patient file, which will remain confidential and stored securely. The personnel in my office who may need to access your file for administrative purposes are also bound by confidentiality. When disclosure of your records is required by law, you will be notified. Most of these provisions were described to you in the notice of privacy practices that you received with the intake packet.

You should be aware of the following exceptions to confidentiality:

1. You provide consent to release your records or to share information regarding your treatment.
2. You are at risk of imminent serious harm to yourself or others*;
3. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person;
4. You disclose sexual misconduct of a physician or therapist;
5. Information is requested by your insurance company pertinent to processing claims for payment;
6. A court order is received to disclose information (e.g. child custody or mental competency cases);
7. You file a complaint with a licensing board or in cases of a malpractice suit; records will be released to the Board and/or legal counsel.

***In the event that you are deemed an imminent danger to yourself or others, your therapist has a professional duty to contact the proper authorities. Medical and/or law enforcement officials may be notified with or without your consent.**

Please indicate in the spaces below who you give consent for me to contact in the event of any emergency:

Name	Phone Number	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Couples/Family Therapy: When seeing couples or families, your therapist will treat as confidential (within the limits cited above) information you disclose that you specifically request not be shared with your partner or family member. However, open communication is encouraged between couples and families, and your therapist may reserve the right to terminate treatment if he/she judges a secret to be detrimental to the therapeutic process. You should be aware that some insurance plans do not cover marital and/or family therapy.

Phone Messages, Fax Transmissions, and Email:

I authorize messages may be left for me regarding appointments or returned calls…(initial all that apply)

____My home answering machine ____With a family member ____My cell phone

____My work voicemail ____Text messaging

Please initial the following:

____ I acknowledge that medical records, insurance information, or other information concerning my treatment may be sent by fax transmission when a release of information has been authorized.

____Emails may be checked only during business hours (not on weekends), and thus should not be used for conveying urgent or highly sensitive information. Be aware that information sent via email is not guaranteed to be secure.

Transfer of Records: In the case of death or incapacity, the therapists in this office have made provision for another mental health provider to take possession of all patient records. In this event, you may contact Kenyatta Black LPC-S for information concerning how to access a copy of your record or how to have your record transferred to another mental health professional of your choosing.

I hereby give my consent for psychological treatment from the therapist signed below. I have read this document carefully and understand the information regarding consent and Cary Scott's services and policies contained herein. Any questions I had were discussed and answered to my satisfaction. I agree to comply with the policies stated. I understand that, should I require services when my therapist is on vacation, this consent is transferable to the covering professional as designated by my therapist. I have been furnished a copy of this statement.

Patient Signature_____ Date _____

Therapist_____ Date_____

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you have access to it.

Protected health information about you is obtained as a record of your contacts or visits for healthcare services with Cary Scott. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

I, Cary Scott, am required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how I follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff. **(Please initial)**

_____ You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

_____ You have the right to authorize other use and disclosure - This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

_____You have the right to designate a personal representative - This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

_____You have the right to inspect and copy your protected health information - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. In certain cases we may deny your request.

_____You have the right to request a restriction of your protected health information - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.

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_____You may have the right to have us amend your protected health information - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

How I May Use or Disclose Protected Health Information
Following are examples of use and disclosures of your protected health care information that I am permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by my office.

For Treatment - I may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, I would disclose protected health information to other physicians who may be involved in your care and treatment. I may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

For Payment -Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services I recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations - I may use or disclose, as needed, your protected health information in order to support the business activities of my practices. This includes, but is not limited to business planning and development, quality assessment and improvement medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

Other Permitted and Required Uses and Disclosures
I may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. I may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law - I may use or disclose your protected health information to the extent that the law requires the use or disclosure.

For Health Oversight - I may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

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In Cases of Abuse or Neglect - I may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, file disclosure will be made consistent with the requirements of applicable federal and state laws.

For Legal Proceedings - I may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Required Uses and Disclosures - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

Complaints You may complain to me or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by me. You may file a complaint with me by notifying myself or to the Texas Department of Health and Human Services. By signing below, you confirm that you have read the above information regarding your Private Healthcare Information.

_____ _____

(Signature of client, or in the case of a minor, their legal guardian)

(Date)

_____

(Printed name of client)