Family Counseling SERVICE

We are grateful that you are entrusting Family Counseling Service to serve you and your family and believe it is important for new clients to understand our scheduling policies before starting services. Please read and initial each policy below and sign at the bottom.

Due to long client wait times for initial and follow up appointments, FCS has implemented the following policies to improve client care.

Please initial each policy to indicate you have been informed of FCS's scheduling policies.

_____ *(initial)* **Intakes (first appointment):** Clients who do not give 48-hour notice of cancelling the intake appointment or "no show" the intake appointment will be referred out of FCS to another provider.

_____ *(initial)* **Follow up appointments:** FCS requires 48-hour notice to cancel and reschedule an appointment over the phone. Clients who fail to give 48-hour notice and clients who "no show" will need to come in to the office to schedule their next appointment. Clients who repeatedly fail to provide 48-hour notice or "no show" may be referred out of FCS to another provider.

_____ *(initial)* **Multiple appointments:** *FCS does not schedule more than one appointment at a time*. You can speak to your therapist about your scheduling needs and we will accommodate you to the best of our ability. In most cases, clients are seen every two weeks. In addition, we utilize a cancellation list to offer clients more timely appointments, when needed. (Requiring 48-hour cancel notification allows us to use the cancellation list effectively.)

_____ _____

Client's Signature Date

_____ _____

Client's Signature Date

FAMILY COUNSELING SERVICE

email: appointments@fcscb.org

Corpus Christi Office
3833 S. Staples, Suite S203
Corpus Christi, TX 78411
361-852-9665
361-852-2794 Fax

Kingsville Office:
603 E Kleberg
Kingsville, TX 78363
361-852-9665
361-592-7843 Fax

We appreciate the confidence you have shown in choosing this office for your therapy needs. We are committed to providing you with the best possible care.

Family Counseling Service is a non-profit agency. You will probably pay a fee that is considerably less than the cost the agency incurs to provide that service. We are able to make up the difference through the United Way allocation, foundation grants, and contributions by individuals.

To aid in this subsidized fee and provide you with a sliding fee scale, Family Counseling Service will accept your group health insurance. Please ask the office assistant for instructions to assist in your filing. You may use Visa, MasterCard, American Express or Discover to charge your fees.

To meet your needs, every effort will be made to schedule a therapy time which is most convenient for you. Our office hours are:

Corpus Christi	Kingsville
8:30 am – 8:00 pm Mon-Thu	9:00 am – 5:00 pm Mon-Wed
8:30 am – 5:00 pm Friday	10:00 am – 6:00 pm Thursday
	No appointments on Friday

Your appointment time is reserved for your exclusive use. To receive the full benefit of your therapy, it is important that you arrive on time for your appointment. Please cancel in advance if you are unable to keep your appointment, otherwise you will be charged a no show fee. This makes it possible to give your scheduled therapy time to a client who may be waiting for an appointment. Your sessions will last approximately 50 minutes.

If you find our services unsatisfactory in any way, you may request a copy of the agency grievance procedure from the office assistant.

Family Counseling Service is available to help people without discrimination by race, color, national origin, religion, sex, age, disability, or sexual orientation. Family Counseling Service can provide sign language services and communication assistance for persons with severe speech impediments as needed. Services may be discontinued if a client is under the influence of drugs or alcohol, uses abusive language or behavior, or refuses to participate in previously agreed upon treatment goals.

Therapy services are voluntary. You may refuse any service offered. While Family Counseling Service does not have legal consequences for services refused, if you are mandated to attend by court order or your employer, the referring agency may have consequences for refusal.

All persons served (and/or their legal guardian) are asked to participate in decisions regarding treatment goals and services provided. Your therapist will ask you about your therapy goals and write these down on a "treatment plan" asking you to sign that you agree.

If a person served becomes overly aggressive, destroys property, is threatening, suicidal, refuses to leave or is extremely intoxicated, the agency may call 911 for law enforcement assistance. There is no use of manual restraint.

Services are confidential except as outlined on the attached blue sheet. We ask you to read it carefully.

If you have questions, please feel free to request a conference.

_____ _____
Client Signature/ Consent **Date**

_____ _____
Client Signature /Consent **Date**

Your Therapist Is: _____

Family Counseling Service
Client Information

Adult Client or Parent/Guardian Information: **Date:** _____

Last Name **First** **Address** **City / State / Zip Code**

_____ **Is it okay to call and leave a message?** ☐ **YES** ☐ **NO**

Home Phone **Cell Phone** **Work Phone**

Date of Birth **Age** **Gender** **Education** **Religion** **Health Insurance Co.**

Email _____

Appointment reminders will be sent by email, if provided.

Which office location do you prefer to be seen at:
☐ Corpus Christi ☐ Kingsville

Occupation **Employed by** **Previous Counseling** **Referred By**

Ethnicity: ☐ Caucasian ☐ African ☐ American Indian ☐ Asian ☐ Hispanic ☐ Other
(Check One)

Marital status: ☐ Single ☐ Separated ☐ Married
(Check one)

What language do you prefer: _____

Household Yearly Income: _____
(Please list income)

Are you seeking services because you are a victim of a crime? ☐ YES ☐ NO

Reason for seeking therapy:

CHILDREN & OTHERS IN HOUSEHOLD:

Name	Date of Birth	Gender	Will you be seeking services for this individual?
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO

Emergency contact information: **Name** _____ **Contact Number:** _____

Spouse/Partner Information:

Last Name **First** **Address** **City / State / Zip Code**

_____ **Is it okay to call and leave a message?** ☐ **YES** ☐ **NO**

Home Phone **Cell Phone** **Work Phone**

Date of Birth **Age** **Gender** **Education** **Religion** **Health Insurance Co.**

Email _____

Appointment reminders will be sent by email, if provided.

What language do you prefer: _____

Occupation **Employed by** **Previous Counseling** **Referred By**

Ethnicity: ☐ Caucasian ☐ African ☐ American Indian ☐ Asian ☐ Hispanic ☐ Other
(Check One)

Marital status: ☐ Single ☐ Separated ☐ Married
(Check one)

For Office Use Only

Patient Type: _____ **Date of First Appointment:** _____ **Therapist:** _____

Family Counseling SERVICE

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3833 S. Staples, Suite S203
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361-852-9665
361-852-2794 Fax

Kingsville Office:
603 E Kleberg
Kingsville, TX 78363
361-852-9665
361-592-7843 Fax

Client Name: _____ **DOB:** _____

Therapist Name: _____

Informed Consent for Tele Mental Health Services

The following information is provided to clients who are seeking Tele Mental Health therapy. This document covers your rights, risks and benefits associated with receiving services, Family Counseling Service policies, and your authorization. Please read this document carefully, note any questions you would like to discuss, and sign.

Tele Mental Health Services Defined:
Tele Mental Health Services means the remote delivering of health care services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes, but is not limited to, video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method used by Family Counselling Service is video and/or telephone.

Limitations of Tele Mental Health Therapy Services:
While Tele Mental Health Services offers several advantages such as convenience and flexibility, it is an alternative form of therapy that may involve disadvantages and limitations. For example, there may be a disruption to the service (e.g. phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues.
Additionally, the therapy office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. Your therapist will take every precaution to insure technologically secure and environmentally private psychotherapy sessions.
Tele Mental Health Therapy is not appropriate for all clients. Your therapist determines on an on-going basis whether the issue being addressed is appropriate for Tele Mental Health Therapy and may need to make referrals if he/she determines it would be unethical to continue such services.

Client Responsibilities for Tele Mental Health Therapy Services:
The virtual sessions can only be conducted while the client is within the state of Texas.
The virtual sessions should be conducted on a Wi-Fi connection for the best connections and to minimize disruption.
Family Counseling Service strongly suggests that you only communicate through a device that you know is safe and technologically secure (e.g. has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.)
Make sure you have checked your company's policy before using a work computer for personal communication.

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As the client, you are responsible for finding a private, quiet location where the sessions may be conducted. **Sessions are not able to take place if other individuals are present in your location, or while operating a motor vehicle.**

Identity and Location:
Your therapist is required to verify your identity and location at the start of each session.

In Case of Technology Failure:
During a Tele Mental Health session there is the potential for a technological failure. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please call the therapist back at 361-852-9665. Please make sure you have a phone with you and that the therapist has that phone number. Your therapist may also reschedule if there are problems with connectivity.

Interactive Video, Electronic Medical Record:
Family Counseling Service utilizes doxy.me for interactive video which includes support 128-bit AES encryption for all signaling. Doxy.me will keep track of your meeting history, including the date, time, and duration of your sessions. EHR Your Way is the HIPAA-compliant web-based program where your Electronic Medical Record will be stored. Your record will be stored by Family Counseling Service 6 years after your final counseling session (for adults) or 6 years past the age of 18 for a client who is a minor.

Emergency Management Plan:
In the event of a mental health emergency, the Nueces County MHID crisis line (888-767-4493) or Coastal Plains Community Center for Kleberg County residents (800-841-6467), and San Patricio County residents (361-446-6567) can be contacted by the client or the therapist. In the event of a life-threatening emergency the client and/or the therapist will contact 9-1-1 emergency services.

Please enter information for the person to contact in the event of an emergency:

Emergency Contact Person: _____

Relationship: _____ Phone Number: _____

I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversations.

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I understand that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

Consent for Tele Mental Health Services Treatment:
I voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize Family Counseling Service to provide such care, treatment or services. I understand and agree that I will participate in the planning of my care, treatment or services and that I may withdraw consent for such care, treatment or services that I receive from Family Counseling Service at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understand all the terms and information contained herein.

Informed Consent for Tele Mental Health Services

Patient/Client Name	Signature	Date
Patient/Client Name	Signature	Date
Parent/Guardian Name	Signature	Date

Please print, sign and fax or email to Family Counseling Service:
appointments@fcscb.org
Fax:
361-852-2794 (Corpus Christi clients)
361-592-7843 (Kingsville clients)

FAMILY COUNSELING SERVICE

For self-pay clients:

I (we) _____ understand that the cost of one hour of therapy to Family Counseling Service is $140 per fifty-minute session.

Because of the subsidy of United Way and private foundations my fee will be _____.

For Insurance, Medicaid and Medicare clients:

I understand that I am responsible for the deductible, if unmet. I am also responsible for the cost share of my fee which insurance does not cover.

I authorize Family Counseling Service to release any information necessary to process an insurance, Medicaid and/or Medicare claim and collect payment. I authorize payment directly to Family Counseling Service for benefits otherwise payable to me.

_____ _____
Client's Signature Date

_____ _____
Client's Signature Date

PRIVACY STATEMENT

I acknowledge that I have received a copy of the Notice of Privacy Practices. Family Counseling Service will administer my/our patient records in a confidential manner and in compliance with the Health Insurance Portability and Accountability Act. A separate authorization must be executed for the non-routine release of Protected Health Information.

Signed _____ Date _____

Signed _____ Date _____

****

For Office Use Only

****

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Other (Please specify) _____

FAMILY COUNSELING SERVICE

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361-592-7843 Fax

Court Testimony Information and Fees

Family Counseling Service specializes in providing therapy services for clients. As an agency we do not specialize in providing court testimony or becoming involved in custodial agreements or home evaluations.

If you reasonably expect that your counseling will result in court related issues, it is highly recommended that you seek out a counselor familiar with and comfortable with testifying and court work. Please discuss this with your therapist.

If a therapist with Family Counseling Service is asked to testify or is subpoenaed by the client's attorney to appear in court and the therapist is required to cancel or block off time then the charge is $150.00 an hour. A retainer of $300.00 for court testimony will be required prior to beginning any court work. Any subsequent charges beyond the $300.00 retainer will be billed or invoiced to the client or the client's attorney. If the therapist is notified within 24 hours prior to the date that court has been postponed or delayed the Agency may waive the fee for any hour that they are able to fill. If the therapist is required to travel, all expenses will be incurred by the client or client's attorney.

If the therapist is requested to provide written professional opinions or summaries for legal proceedings then the standard fees will be applied for letter writing or provision of records. Such a request must be in writing on the *Client Request of Record Form*.

Letter writing

$20.00 - Letter with only dates of client's visits.

$50.00 - Letter with: dates of visits, treatment goals, progress (or lack of).

$65.00 – Letter with: dates, treatment goals, progress (lack of), file review, and recommendations.

Records Release

$30.00 – Single Client: review of file and copy of assessment and progress notes ($.50 for each additional page beyond 5 sheets.)

$40.00 – Multiple Client Record: review of file to blacken out information that pertains to other person in assessment, progress notes, etc… not included on signed release from client. ($.50 for each additional page beyond 5 sheets.)

Consultations with your attorney or an opposing attorney, calls or emails relating to your case or conflict as well as preparation for court will be billed at $100.00 per hour based on quarterly increments.

If you have further questions regarding court testimony or fees please, consult with your therapist.

(Signature of Client/Legally Authorized Representative) (Today's Date) (Printed Name)

_____
(Relation to client)

FAMILY COUNSELING SERVICE
Client Medical History

Parents: If your child will be seen answer this on yourself (There is a separate form for your child.)

Name: _____ Date: _____

1. **Primary Care Physician's Information**

Name: _____ Phone Number: _____

Address: _____

Would you like us to coordinate your care with your primary care physician? Yes No

If yes, would you be willing to sign a release of information? Yes No

2. **Psychiatrist's Information** (if applicable)

Name: _____ Phone Number: _____

Address: _____

Would you like us to coordinate your care with your psychiatrist? Yes No

If yes, would you be willing to sign a release of information? Yes No

	Yes	No
3. Do you have a history of medical problems; accidents, illnesses, injuries, surgeries, communicable diseases?		
4. Do you have any current medical conditions or illnesses that are a concern to you?		
5. List any known allergies to medication, food, or airborne material:		
6. Have you ever been diagnosed with a mental disorder? If so, please list:		
7. Have you had a head injury?		

If you are taking medication, please provide as much of the following information as possible.

Medication	Dose	How often do you take this medication?	Doctor who prescribed this medication	Used for

FAMILY COUNSELING SERVICE
Client Check List Part One

Parents: If your child will be seen answer this on yourself. (There will be a separate form for your child.)

Name: _____ Date: _____

	Yes	No
1. Have you had previous counseling?		
2. Do you live alone?		
3. Have you changed jobs/schools in the last two years?		
4. Are you experiencing financial problems?		
5. Are you here regarding legal issues?		
6. Do you like going to work/school?		
7. Do you have sexual concerns?		
8. Have you or others been concerned about your alcohol or drug use?		
9. Do any family members have alcohol or drug problems?		
10. Do you starve yourself or make yourself throw up?		
11. Do you feel that you are in danger?		
12. Do you have thoughts about hurting yourself?		
13. Do you have any thoughts about hurting others?		
14. Do you find it hard to talk about personal problems with other people?		
15. Have you lost hope that your problem(s) can be resolved?		
16. Do you have motivation to work on your issues?		
17. Do you have faith in a higher power?		

Please place a check the box for each question to indicate how much (or how often) have you been bothered by the following problems in the **past 2 weeks**.	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
1. Sleeping less than usual but still have a lot of energy?					
2. Starting lots more projects than usual or doing more risky things than usual?					
3. Unexplained aches and pains (e.g. head, back, joints, abdomen, legs)?					
4. Hearing things other people could not hear, such as voices even when no one was around?					
5. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?					
6. Problems with memory?					
7. Unpleasant thoughts, urges or images that repeatedly enter your mind?					
8. Feeling driven to perform certain behaviors or mental acts over and over again?					
9. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?					
10. Drinking at least 4 drinks of any kind of alcohol in a single day?					
11. Smoking any cigarettes, a cigar, or pipe, or using snuff, chewing tobacco or any other form of nicotine?					
12. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed: pain killers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?					

Adapted from DSM 5 Self-Rated Level 1 Cross-Cutting Symptom Measure

FAMILY COUNSELING SERVICE
Client Check List Part Two

Parents: If your child will be seen, you may skip this questionnaire.

Name: _____ Date:_____

GAD-7

During the **past 2 weeks**, how much (or how often) have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day	
1. Feeling nervous, anxious or on edge.	0	1	2	3	
2. Not being able to stop or control worrying.	0	1	2	3	
3. Worrying too much about different things.	0	1	2	3	
4. Trouble relaxing.	0	1	2	3	
5. Being so restless that it is hard to sit still.	0	1	2	3	
6. Becoming easily annoyed or irritable.	0	1	2	3	
7. Feeling afraid something awful might happen.	0	1	2	3	**Total Score:**
Total					

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not at all	Somewhat difficult	Very difficult	Extremely Difficult

Developed by Drs. Robert L. Spitzer, Jane B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer, Inc.

PHQ-9

During the **past 2 weeks**, how much (or how often) have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day	
1. Little interest or pleasure in doing things.	0	1	2	3	
2. Feeling down, depressed or hopeless.	0	1	2	3	
3. Trouble falling asleep or staying asleep, or sleeping too much.	0	1	2	3	
4. Feeling tired or having little energy.	0	1	2	3	
5. Poor appetite or overeating.	0	1	2	3	
6. Feeling bad about yourself - or that you are a failure or have let yourself go.	0	1	2	3	
7. Trouble concentrating on things, such as reading the newspaper.	0	1	2	3	
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3	
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3	**Total Score:**
Total					

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not at all	Somewhat difficult	Very difficult	Extremely Difficult

Developed by Drs. Robert L. Spitzer, Jane B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer, Inc.

Family Counseling Service

Consent for Treatment of Minors

3833 S. Staples, Suite S203, Corpus Christi, TX 78411
Phone: (361) 852-9665 Fax: (361) 852-2794

603 E Kleberg, Kingsville, TX 78363
Phone: (361) 852-9665 Fax: (361) 592-7843

Family Counseling Service is dedicated to serving families. Whenever possible, it is beneficial for both parents to be involved in therapy; therefore we request that *both* parents sign consent for their child to participate in therapy.

When there is an active or current custody dispute, Family Counseling Service is *required* to have both parents sign consent for services. Family Counseling Service is also *required* to obtain a copy of the most current legal custody agreement or court order.

Please initial the statement that best describes your situation:

___ *(parent initials)*
___ *(parent initials)* I understand that Family Counseling Service requests that both parents sign consent for services and I will make every attempt to comply with this request. I understand it is my responsibility to communicate with my child's parent regarding this issue.

___ *(parent initials)*
___ *(parent initials)* I understand that Family Counseling Service requests that both parents sign consent for services, however I am unable to comply with this request for the following reason(s):

_____

_____

___ *(parent initials)*
___ *(parent initials)* There is a current custody dispute involving my child and I will assume the responsibility of communicating with my child's parent regarding consent for services. I understand my child may not be allowed to participate in therapy services if both parents do not sign consent for services.

___ *(parent initials)*
___ *(parent initials)* I understand that Family Counseling Service requires both parents sign consent for services, however I am unable to comply with this requirement for the following reason(s):

_____

_____

___ *(parent initials)*
___ *(parent initials)* There is a current legal custody agreement or court order for my child. **I understand I must provide a copy of this agreement before an appointment will be scheduled.** I also understand my child may not be allowed to participate in therapy services if I do not provide a copy of this custody agreement.

___ *(parent initials)*
___ *(parent initials)* I understand that Family Counseling Service requires a copy of the current legal custody agreement, however I am unable to comply with this requirement for the following reason(s):

_____

_____

_____
(Signature of Client/Legally Authorized Representative) (Today's Date) (Printed Name)

_____
(Signature of Client/Legally Authorized Representative) (Today's Date) (Printed Name)

_____
(Name/names of children)

FAMILY COUNSELING SERVICE
Child/Adolescent Medical/Developmental History

Child's Name: _____ Date of Birth: _____ Age: _____ Date: _____

1. **Primary Care Physician's Information**

Name: _____ Phone Number: _____

Address: _____

Would you like us to coordinate your care with your child's primary care physician? Yes No

If yes, would you be willing to sign a release of information? Yes No

2. **Psychiatrist's Information** (if applicable)

Name: _____ Phone Number: _____

Address: _____

Would you like us to coordinate your care with your child's Psychiatrist? Yes No

If yes, would you be willing to sign a release of information? Yes No

3. How would you describe your child's overall mood? (Circle one)

Positive (happy, laughing, upbeat, hopeful) **Negative (depressed, angry, irritable)**

Mixed but more positive than negative **Mixed but more negative than positive**

	Yes	No
4. Did the mother experience any physical or emotional problems during pregnancy? If yes, specify:		
5. Did the mother consume alcoholic beverages or abuse any street drugs during pregnancy? If yes, specify:		
6. Is there a history of physical, sexual or emotional abuse? If yes, specify:		
7. Is there a history of prolonged separations or traumatic events? If yes, specify:		
8. Has your child ever been diagnosed with a mental disorder? If yes, specify:		
9. Please list your child's grade: What school is your child attending?		
10. Is your child currently receiving special services in school? If yes, specify:		
11. Has your child ever failed a class or been held back for academic reasons?		
12. Has your child had previous counseling?		
13. Does your child have faith in a higher power? If so, please state religious preference:		

If your child is taking medication, please provide as much of the following information as possible.

Medication	Dose	How often does your child take this medication?	Doctor who prescribed this medication	Used for

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?						
	2.	Said he/she was worried about his/her health or about getting sick?						
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?						
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?						
IV.	5.	Had less fun doing things than he/she used to?						
	6.	Seemed sad or depressed for several hours?						
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?						
	8.	Seemed angry or lost his/her temper?						
VII.	9.	Started lots more projects than usual or did more risky things than usual?						
	10.	Slept less than usual for him/her, but still had lots of energy?						
VIII.	11.	Said he/she felt nervous, anxious, or scared?						
	12.	Not been able to stop worrying?						
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?						
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?						
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?						
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?						
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?						
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?						
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?						
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	❑ Yes	❑ No	❑ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	❑ Yes	❑ No	❑ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	❑ Yes	❑ No	❑ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	❑ Yes	❑ No	❑ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	❑ Yes	❑ No	❑ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	❑ Yes	❑ No	❑ Don't Know			

Family Counseling SERVICE

CLIENTS RIGHTS AND RESPONSIBILITIES

Family Counseling Service is a not-for-profit agency.

If your service requires a fee it may be subsidized through the United Way, foundation grants, and contributions.

You may use VISA , MasterCard, American Express, or Discover to charge your fees.

Family Counseling Service will accept group health insurance.

Regular agency hours are from 8:30 a.m. to 8 p.m. Monday through Thursday, and 8:30 a.m. to 5 p.m. on Friday.

Family Counseling Service requires the completion of all necessary paperwork in order for you to begin services.

A grievance procedure is available. See front office staff for information.

Services are available to people without discrimination by race, color, national origin, religion, sex, age, sexual orientation, sexual identity or disability.

Sign language and other accommodations are provided upon request.

Services may be discontinued if a client is under the influence of drugs or alcohol, is using threatening language or behavior and/or is refusing to cooperate with FCS procedures.

All counseling services at Family Counseling Service are voluntary. However, if you are mandated by court or law, the referring agency may have consequences for refusal.

Persons served, parents, and/or legal guardians of minor children will be asked to participate in and sign treatment goals.

Services are confidential with the exceptions as outlined on the “Information for Clients Regarding Confidentiality” form.

Please request a conference with the Director of Clinical Programs if you have questions regarding this information.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Understanding Your Mental Health Record Information:

Each time you visit a mental health care provider, the provider makes a record of your visit. Typically, this record contains your history, current symptoms, diagnosis, and a treatment plan. This information, often referred to as your mental health record, serves as a:

*basis of planning your care and treatment.
*means of communication among professionals who contribute to your care.
*legal document describing the care you received.
*means by which you or a third-party payer can verify that you actually received the services billed for.
*a tool to assess the appropriateness and quality of care you received
*a tool to improve the quality of mental health care and achieve better outcomes.

Understanding what is in your mental health records and how this information is used will help you to:

*ensure its accuracy and completeness.
*understand who, what, where, why and how others may access your record
*make informed decisions about authorizing disclosure to others.
*better understand the mental health information rights detailed below.

We will not use or disclose your mental health information without your authorization, except as described in this notice or otherwise required by law.

Uses and Disclosures: With the regulatory consent granted by the Department of Health and Human Services we may use or disclose your mental health information for treatment, payment, and operations.

Treatment: Your counselor will record information in your record about the issues that you wish to discuss and the treatment plan that you develop together to address these issues. He/she will then document actions taken and observations of each session in order to determine whether or not you are progressing toward your goals.

Payment: Your mental health information may be used to seek payment from your health plan. For example, your mental health plan may request and receive information on dates of services, the services provided and the mental health condition being treated.

Health Care Operations: Your mental health information (which has been de-identified) may be used as necessary to support the day-to-day activities and management of Family Counseling Service. For example, information on the services you received may be used to assess the care and outcomes in your case and the competence of the counselor/advocate. We will use this information in an effort to continually improve the quality and effectiveness of our services.

Uses and Disclosures Other than for Treatment, Payment or Health Care Operations:

Law Enforcement: We may disclose mental health information for purposes as required by law or in response to a valid subpoena.

Public Health Reporting: Your mental health information may be disclosed to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agency thereof mental health information necessary for your mental health and the health and safety of other individuals.

Health Oversight Agencies and Public Health Authorities: If a member of our work force or a business associate believes in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public, they may disclose your mental health information to health oversight agencies and/or public health authorities such as the Department of Health.

The Federal Department of Health and Human Services (DHHS): Under the privacy standards, we must disclose your mental health information to DHHS as necessary for them to determine our compliance with those standards.

Other uses and disclosures require your authorization: Disclosure of your mental health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Continuity of Care: We may contact you to provide appointment reminder, or you or your child may be given a school/work excuse for missed time due to an appointment.
We may contact you after services have been completed regarding your satisfaction with our services.

Individual Rights:
You have certain rights under the federal privacy standards. These include:

* The right to request restrictions on the use and disclosure of your protected mental health information; we are not required to accept the restrictions. However, if accepted, we will comply with the restrictions.
* The right to receive confidential communications concerning your mental health condition and treatment.
* The right to inspect and copy your protected mental health information.
* The right to amend or submit corrections to your protected mental health information. Amendments to your information may be limited; the Privacy Officer will notify you of any changes that cannot be made and why. If your information is corrected, we will endeavor to identify any party who received the incorrect information and provide them with the corrected information.
* The right to receive an accounting of how and to whom your protected mental health information has been disclosed. Contact the Privacy Officer so that you may fill out a written request, and please allow 60 days.
* The right to receive a printed copy of this notice.

Limitations on Individual Access:
Access to your protected mental health information may be limited or restricted in the following circumstances:

* Psychotherapy notes
* Information compiled in anticipation of, or for use in, a civil, criminal or administrative action or proceeding.
* Information that was obtained from someone other than a health care provider under a promise of confidentiality and release of the information would likely reveal the source.

Should your access to your information be limited or restricted, you may have the denial reviewed by the Privacy Committee.

Family Counseling Service Duties:

We are required by law to maintain the privacy of your protected mental health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

We are required to train our personnel concerning privacy and confidentiality and implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard to them.

Right to Revise Privacy Practices:
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in Federal and State laws and regulations. Whatever the reason for these revision, we will

provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected mental health information that we maintain.

Requests to Inspect Protected Mental Health Information:
As permitted by Federal regulation, we require that requests to inspect or copy protected mental health information be submitted in writing. You may obtain a form to request access to your records by contacting Maria Graciano, Director of Clinical Programs, Family Counseling Service Privacy Officer.

Please know that it is permitted by law to charge a reasonable fee for copying and expenses related to a request for protected mental health information and records.

Complaints:
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Maria Graciano, MS, LPC-S, RPT-S
Family Counseling Service
3833 S. Staples, Suite S-203
Corpus Christi, TX 78411
(361) 852-9665

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

The above mentioned person is also the person you can contact for further information concerning our privacy practices.

Effective Date:
This notice is effective as of April 14, 2003.

Client Signature_____ Date: _____

Client Signature_____ Date: _____

3833 S Staples, S203
Corpus Christi, TX 78411
361-852-9665

Family Counseling Service

603 E Kleberg
Kingsville, TX 78363
361-852-9665

INFORMATION FOR CLIENTS REGARDING CONFIDENTIALITY

THERAPY PROGRAM

We place a high value on the confidentiality of the information that our clients share with us. This sheet was prepared to clarify our legal and ethical responsibilities regarding this important issue.

Personal information that you share with us may be entered into your records in written form. However, an effort is generally made to avoid entry of information which may be especially sensitive or embarrassing. The only individuals with access to our files are staff members who are either directly involved in providing services to you, those performing related clerical tasks, insurance companies that monitor mental health care services, and professional accreditation persons bonded in the same code of confidentiality who audit files to assess quality service.

RELEASE OF INFORMATION TO OTHERS

If for some reason there is a need to share information in your record with someone not employed here (for example, your physician or another therapist), you will first be consulted and asked to sign a form authorizing transfer of the information. Because of the sensitive nature of the information contained in some records, you may wish to discuss the release of this material and related implications very carefully before you sign. The form will specify the information which you give us permission to release to the other party and will specify the time period during which the information may be released. You can revoke your permission at any time by simply giving us written notice.

EXCEPTIONS TO CONFIDENTIALITY

There are several important instances when confidential information may be released to others. First, if you have been referred to this agency by the Court ("court ordered"), you can assume that the Court wishes to receive some type of report or evaluation. You should discuss with us exactly what information may be included in a report to the Court before you disclose any confidential material. In such instances, you have a right to tell us only what you want us to know.

Second, if you are involved in litigation of any kind and inform the court of the services that you received from us (making your mental health an issue before the court), you may be waiving your right to keep your records confidential. You may wish to consult your attorney regarding such matters before you disclose that you have received treatment.

Third, if you threaten to harm either yourself or someone else and we believe your threat to be serious, we may divulge circumstances to law enforcement or medical personnel where someone's life appeared to be in danger.

Fourth, if we have reason to believe that you are abusing or neglecting your children or vulnerable adults, we are obligated by law to report this to the appropriate state agency. The law is designed to protect children and vulnerable adults from harm and the obligations to report suspected abuse or neglect are clear in this regard.

There may be some other rare instances in which you waive your rights to have your records protected. If you are involved in any type of current or potential legal difficulties, we suggest that you discuss such matters with your attorney before informing others of the services you have received here.

In summary, we make every reasonable effort to safeguard the personal information which you may share with us. As noted above, however, there are certain instances when we may be obligated under the law to release such information to others. If you have any questions about confidentiality, please discuss them with us.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____