Mary Thory, M.A., LPC

Personal Data Record

Client Name: _____ Date of Birth:_____

Address: _____

City/State/Zip:_____

Home Phone: _____ Cell Phone: _____

Email: _____

Permission to text: Yes _____ No_____
Permission to leave voice message: Yes_____ No _____
Permission to email: Yes _____ No_____

Referred by: _____
May I send a Thank You card to the person who referred you? (circle one) Yes No
May I mention your name in that Thank You card? (circle one) Yes No

Payment Information

MC/Visa/Discover No. _____Exp. Date: _____

Name as Listed on Card: _____

Security Number (on back of card): _____

Signature of Authorized User: _____

Emergency Contact

Name: _____ Relationship:_____

Address: _____

Phone: _____

Information & Consent

I am honored that you have selected me to provide counseling for you.I wish to do my best to assist you in making this experience meaningful and fruitful. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I have a master's degree in Child Development and Family Studies and have worked with children and adults in many different capacities. I also have a master's degree in counseling and am recognized by the state of Texas as a Licensed Professional Counselor. My expertise includes child, adolescent, adult, family and group counseling.

I believe clients have the capacity to resolve their own problems and make their own decisions with my assistance as a facilitator. I view the therapeutic relationship as a collaboration between my client and myself. Together clients and I work toward goals that are set together. Some clients need only a few counseling sessions to achieve their goals, while others may need months or even longer. As a client you maintain control of yourself and may end our counseling relationship at any point. I will be supportive of that decision. If counseling is successful, you should feel you are able to face life's challenges without the support or intervention of a counselor and you should feel a sense of success in satisfactorily resolving your problem(s).

My expectations of my clients are to keep scheduled appointments, be forthright about issues and goals and take an active and engaging role in the process.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather that a social one. Our contact will be limited to the sessions you arrange with me. It may be confusing or counter-productive for me to accept gifts or be invited to social gatherings. You are best served by experiencing me in my professional role.

I believe that everyone is doing the best they can with what they have available to them. Life throws us all kinds of challenges, but the only thing we really have control over is our own thoughts and behaviors. Through both professional and personal experiences I have found that our thoughts guide our emotions which then guide our behavior.

Because of these beliefs, I work mainly with Cognitive Behavioral Therapy, but also use a mixture of therapeutic techniques to meet the individual needs of my clients. The strategies I use are aimed at cognitive restructuring, and behavioral changes, but also with the exploration and understanding of emotions. I use strategies such as

reinforcement and support, problem solving, thought stopping, reframing, systematic decision making, questioning, journaling, role playing, focusing on the positive, relaxation, EMDR and occasionally homework. I use other approaches when deemed appropriate for the client(s).

I will keep confident the things you tell me with the following exceptions: (a) you direct me to tell someone else, and I agree to do so, (b) I decide you are a danger to yourself or others, (c) I am ordered by court to disclose information, (d) you disclose abuse of a child, or disabled or elderly person, (e) in a previous therapeutic relationship, your counselor sexually exploited you, (f) you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to other parties, (g) other reason as specified in laws of this state. A written record of our counseling sessions will be maintained by me.

I assure you that our work will be conducted in a conscientious manner consistent with accepted ethical standards. Please note that it is not possible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results.

Unless children are seen in the context of treatment I request that you make alternative childcare arrangements during your sessions so that our full attention can be devoted to your priorities.

Having read the policies above, I agree to all policies, financial obligations and agree that this contract replaces any earlier contracts. Additionally, I understand that there can be no absolute guarantee of cure in the practice of counseling.

I give full consent for myself or my child/adolescent to receive outpatient mental health services until I notify Mary Thory of any changes or until it is determined that treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for myself or my child/adolescent.

_____ _____

Client Name Date of Birth

_____ _____

Authorized Signature Date

Mary Thory, M.A., LPC

Office Policies

1. ____ Initial:

Fees Schedule: All fees for services are due at the time of the appointment.
Session Fee: $135.00 (50 minute duration) or insurance copay.

2. ____ Initial:

Miscellaneous: Charges for other professional services are prorated on the basis of $135.00 per hour, 15 minute increments. These services include, but are not limited to, phone calls, third-party consultations and correspondence. Off-site consultation is prorated at the rate of $135.00 per hour, “portal to portal”, that is, for the time I am out of the office on your behalf.

3. ____ Initial:

Legal Testimony: Please be advised that I do **not** provide consultation, evaluation or legal expert testimony in child custody, child visitation or molestation cases. Similarly, I do not consider my practice to include expert testimonials. However, should my opinion be so ordered, fees will be charged at the rate of $500.00 per hour, portal to portal. This fee will apply as well to depositions or interrogatories. All fees of this nature are payable in advance.

4. ____ Initial:

Cancellations: The scheduling of an appointment involves the reservation of time specifically for you. **24 hours cancellation notice is required** so that there will be no charge to your account. Cancellations made within 24 hours of an appointment will be charged at full rate. Insurance companies do not pay for late cancellations or no shows so clients using insurance will have to pay the full fee. PLEASE CALL OR TEXT TO CANCEL AN APPOINTMENT. EMAIL IS NOT MONITORED FOR CANCELLATIONS.

5. ____ Initial:

Confidentiality: All information disclosed within sessions is confidential and may not be revealed to anyone without written permission except where disclosure is required by law. Disclosure may be required in the circumstances where there is reasonable suspicion of child or elder abuse and where there is reasonable suspicion that the client is likely to harm himself/herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding.

6. ____ Initial:

After Hours Emergency Procedure: If a true emergency arises, please dial 911 and inform the operator that you have an emergency. Also, please call Mary Thory at 281–687-8280.

7. ____ Initial:

Children can be joyful and energetic, but with respect to the concerns which brought you along with our other clients to us, I request that you obtain a sitter for children not receiving treatment so that our full attention can be devoted to your priorities.

Insurance Information

Client's Name: _____Date of Birth:_____

Insurance Co.: _____

Policy No.: _____ Group No.: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

I request that payment of authorized insurance benefits be made on my behalf to Mary Thory, MA, LPC for professional services rendered to me or my dependent. The undersigned is financially responsible for fees not paid pursuant to this agreement. I authorize any holder release of medical information as may be required for the completion of my claims, including a third party billing company. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of client: _____

Date: _____

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

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

I. Uses and Disclosures Requiring Authorization

- "PHI" refers to information in your health record that could identify you.

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

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I 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.

II. Uses and Disclosures with Neither Consent nor Authorization

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

- Child Abuse: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I 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.

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

- Sexual Misconduct by a therapist: If you report to me any situation that constitutes sexual misconduct by a current or former therapist, then I am required to inform the licensing authority of the offending therapist.

- Regulatory Oversight: If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information 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 I 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 I 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, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **- Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

III. Client's Rights and Our Professional Duties
Client's Rights:
- Right to Request Restrictions –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeking our services. Upon your request, I will send bills or other correspondence to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, I 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 in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

My Professional Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will post a current copy in our offices.A current copy will always be available on my web site and you may request a personal copy.

IV. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, please contact me, Mary Thory, at 281-687-8280. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

V. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 6-28-2016. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in our lobby and on my web site. You may request a personal copy at any time.

Intake Assessment Form

Client's name: _____ Date: _____

Gender: ____ F____ M Date of birth: _____ Age: _____

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

Primary reason(s) for seeking services

___ Anger management ___ Anxiety ___ Coping ___ Depression

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

___ Sleeping problems ___ Addictive behaviors ___ Alcohol/drugs

___ Other mental health concerns (specify): _____

COUNSELING/PRIOR TREATMENT HISTORY

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment	____	____	_____	_____	_____
Suicidal thoughts/attempts	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	_____	_____	_____

Information about family/significant others (past and present): _____

_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

____ Aggression
____ Alcohol dependence
____ Anger
____ Antisocial behavior
____ Anxiety
____ Avoiding people
____ Chest pain
____ Cyber addiction
____ Elevated mood
____ Fatigue
____ Gambling
____ Hallucinations
____ Heart palpitations
____ High blood pressure
____ Hopelessness
____ Impulsivity
____ Phobias/fears
____ Recurring thoughts
____ Sexual addiction
____ Sexual difficulties
____ Sick often
____ Sleeping problems
____ Speech problems
____ Suicidal thoughts

____ Depression
____ Disorientation
____ Distractibility
____ Dizziness
____ Drug dependence
____ Eating disorder
____ Irritability
____ Judgment errors
____ Loneliness
____ Memory impairment
____ Mood shifts
____ Panic attacks
____ Thoughts disorganized
____ Trembling
____ Withdrawing
____ Worrying
____ Other (specify): _____
_____

Briefly discuss how the above symptoms impair your ability to function effectively: _____

_____

_____

What are your goals for therapy? _____

_____

_____

Do you feel suicidal at this time? ____ Yes____ No

If Yes, explain: _____

Medical/Physical Health

List any significant past health concerns:_____

List any current health concerns: _____

List any recent health or physical changes: _____

_____

Current prescribed medications Dose Dates Purpose Side effects

_____

_____

_____

_____

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

_____

_____

_____

_____

Are you allergic to any medications or drugs? ____ Yes____ No

If Yes, describe: _____

_____

Family history of medical problems: _____

_____

Please check if there have been any recent changes in the following:

____ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level

____ Physical activity level ____ General disposition ____ Weight ____ Nervousness/tension