Massey Counseling, PLLC
Individual
Couple
Family

Yvette Massey, MA, LPC, CST **210-887-1670** **ymassey@mc.hush.com**
19206 Huebner, Suite 104, San Antonio, TX 78258

ADULT CLIENT INFORMATION FORM

Thank you for taking the time to fill out this form. The information you provide is confidential and will be helpful when you meet with your counselor for the first time. Please discuss any questions you may have.

Who referred you to this office? ____

Name ____Today's Date_____ ___________________

Address____
Street City State Zip

Age_______ Date of Birth____/____/____ ◯ Male ◯ Female ◯ Other ____________
Preferred Pronoun: ________________________

Home Phone:________________________________ May we leave a message? ◯ Yes ◯ No

Cell/Other Phone:____________________________ May we leave a message? ◯ Yes ◯ No

Email: ______________________________________ May we e-mail you? ◯ Yes ◯ No

Employer:___________________________________ Occupation: _________________________________

Highest level of education __________________________________ Area of Study____________________

Current Relationship Status:
◯ Married (how long_____) ◯ Widowed (how long_____) ◯ Divorced (how long____)
◯ Separated (how long_____) ◯ Living Together (how long_____) ◯ Never Married

Relationship History - Please provide information and duration of additional marriages and/or significant relationships:____

____

Current Household: please list name, age, gender, and relationship of your children and any other members of your household.

Name	Relationship	Age	Gender	Living with you?

Presenting problems and/or stressor and what you would like to gain from counseling: ____________________

____

____

____

PSYCHOSOCIAL INFORMATION

Name: ____________________________________ **Date:** _________________

Health and Personal Information:

Please describe your current physical health: ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Please describe your current diet: ◯ Excellent ◯ Good ◯ Fair ◯ Poor

How many hours do you sleep at night? _______ Do you work out regularly? ◯ Yes ◯ No

Do you smoke or use other tobacco products? ◯ Yes ◯ No If so, please specify ________________

Do you drink alcoholic beverages? ◯ Yes ◯ No If so, please specify ________________

Do you use recreational drugs? ◯ Yes ◯ No If so, please specify ________________

Do you currently have any physical problems, medical conditions, or disabilities? ◯ Yes ◯ No

If so, please explain ____

Have you ever been diagnosed, treated, or hospitalized for a mental illness? ◯ Yes ◯ No

If so, please provide dates, reasons, and treatment providers ____
____

Are you on any medications? ◯ Yes ◯ No If so, please provide the following information:

Medication	Dosage	Physician	Purpose	How long

Have you participated in counseling before? ◯ Yes ◯ No If so, please provide dates and reasons:______
____

Are you a survivor of any of the following forms of abuse? ◯ Emotional ◯ Sexual ◯ Physical

History of substance abuse or addiction? ◯ Yes ◯ No If so, please explain: _______________________

Legal History (arrests, prison, DWI, Parking tickets)? ◯ Yes ◯ No Please provide dates and reasons:
____

Are any of these issues causing you distress?

____ Relationship(s) ____ Affair ____ Alcohol/drugs ____ Mood swings ____ Hallucinations
____ Divorce/separation ____ Finances ____ Stress control ____ Other addictions ____ Eating disorder
____ Being single ____ God/Faith ____ Fatigue ____ Grief/loss ____ Hopelessness
____ Sexual issues ____ Weight ____ Self-Mutilation ____ Loneliness ____ Depression
____ Marriage ____ Attention ____ Self-esteem ____ Fear/anxiety ____ Hearing voices
____ School/career ____ Irritability ____ Concentration ____ Pornography use ____ Loss of interest

Do you possess any of these virtues/strengths?

____ Integrity ____ Creativity ____ Curiosity ____ Open-mindedness ____ Love of learning
____ Leadership ____ Vitality ____ Love ____ Kindness ____ Social Intelligence
____ Gratitude ____ Forgiveness ____ Humility ____ Prudence ____ Self-control
____ Fairness ____ Hope ____ Humor ____ Spirituality ____ Wisdom

Spiritual Information: Are spiritual/religious matters important to you? ◯ Yes ◯ No
Are you affiliated with a spiritual/religious group? ◯ Yes ◯ No Describe: ___________________________

Support Network:
____ Spouse/Partner ____ Family ____ Friends ____ Church/Mosque/Temple ____ Other

Hobbies, special interests, sports, and leisure activities: ____

Family Social Information:
I would describe my friendships as: ◯ Close ◯ Somewhat Close ◯ Distant ◯ Conflicted
I would describe relationship with my mother as: ◯ Close ◯ Somewhat Close ◯ Distant ◯ Conflicted
I would describe relationship with my father as: ◯ Close ◯ Somewhat Close ◯ Distant ◯ Conflicted
On average how many times per month do you socialize with family? ________ with friends? _________

Please provide the following information about your siblings:

First Name	Brother or Sister	Age	How would you describe your relationship?

Family Mental Health History: Please identify family members with the specified mental health history:

Mental Health Issue	Yes/No	If yes, list relationship i.e. mother, grandfather, aunt, etc.
Alcohol/Substance Abuse		
Anxiety		
Bipolar		
Depression		
Domestic Violence		
Eating Disorders		
Obsessive Compulsive Behavior		
Schizophrenia		
Suicide Attempts		

Crisis Information: Are you having any current suicidal thoughts, feelings, or actions? ◯ Yes ◯ No
If yes, explain____

Any current homicidal or violent thoughts or feelings, or anger-control problems? ◯ Yes ◯ No
If yes, explain____

Any issues, hospitalizations, or imprisonments for suicidal or assault behavior? ◯ Yes ◯ No
If yes, explain ____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? ◯ Yes ◯ No
If yes, describe____

Emergency Contact: Name:________________________________ Relationship:____________________

Home Phone:____________________ Cell Phone: __________________ Work Phone:_________________

Address:____
Street City State Zip

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CONSENT AND SERVICES AGREEMENT

Welcome! We are providing this information so you can make an informed consent for counseling services. Please read the information carefully. If you have any questions ask your counselor for clarification.

Benefits and Risks of Counseling: The potential benefits of counseling are many (i.e. improved personal functioning, improved relationships, increased self-esteem, improved mood, the attainment of personal goals). In some cases individuals may feel worse after counseling. Clients should understand that healing and growth is a difficult process. As counseling continues, discomfort often leads to positive outcomes.

Counselor and Treatment Approach: Yvette Massey is a Licensed Professional Counselor (LPC) in the State of Texas. She provides mental health and sex therapy services to adult individuals, couples, and families. Her credentials include a BA in psychology and an MA in counseling from the University of Texas at San Antonio. She is a Certified Sex Therapist through the American Association of Sexuality Educators, Counselors, and Therapists (AASECT). Yvette uses Person-Centered Therapy, which views the client-counselor relationship as an important aspect of positive change. This approach is based on the belief that growth occurs best in a genuine, nonjudgmental, empathetic atmosphere. She also uses techniques from Cognitive Behavioral Therapy (CBT), Dialectic Behavioral Therapy (DBT), and the PLISSIT model of sex therapy. Faith based counseling can be provided at client's request

Client Involvement: Success in counseling is directly related to client involvement. It is important for you to be committed to the counseling process by keeping scheduled appointments, arriving on time, and being open and honest during counseling sessions. It is also important for you to continue the counseling work between sessions by working toward stated goals, completing assignments, and being aware of thoughts, feelings, and behaviors which may affect positive outcomes.

Counseling Sessions: The initial session is used for gathering information and assessing your situation. The counselor will work with you to identify and develop treatment goals and a plan for achieving them. Sessions are scheduled for 45-60 minutes once a week or bi-weekly. As you make progress, the frequency of these sessions will decrease as determined by ongoing discussions between you and your counselor.

Referrals: Your counselor may not be able to provide appropriate treatment or services for all the challenges or situations you may face. If you or your counselor decide that a referral is necessary, you will be provided with a referral. You will be responsible for contacting and evaluating that referral.

Complaint Procedure: Your counselor will provide services in a professional manner consistent with accepted legal and ethical standards. If you become dissatisfied with the services, please notify your counselor so a workable solution may be found. If your counselor is unable to resolve your concerns, address your complaints to: TX State Board of Examiners of Professional Counselors; Complaints Management and Investigative Section; P.O. Box 141369; Austin, Texas 78714-1369; or call 1-800-942-5540.

Confidentiality: All communications and records with your counselor are held in strict confidence. Usually, no information will be released without the client and/or legal guardian's written authorization, unless it is required by state or federal law. Possible exceptions to confidentiality include but are not limited to:

1. Abuse or neglect of minors; abuse, neglect, or exploitation of the elderly or disabled.
2. The client expresses serious intent to harm self or someone else.
3. To acquire payment for services or for billing purposes.
4. A subpoena or court order is received directing the disclosure of information.
5. Civil lawsuit brought against the counselor, or representatives, by you or your family.
6. Licensing, certifying, professional association, state department, or governmental entity review boards which are investigating a complaint against the counselor.

Electronic Communication: Electronic communications are not secure methods of communication. There is some risk to confidentiality when using these methods. Your counselor may communicate with you through these mediums. If you prefer not to be contacted by telephone, text, or email, please let your counselor know so other arrangements can be made.

Group Therapy: Confidentiality will be addressed in the group setting. Your counselor is not responsible for any breaches of confidentiality by group members.

Minors: Confidentiality will be provided to minor clients under the following stipulations: Parents/guardians agree that counselor will provide nonspecific, general information about client's progress. More specific information will be supplied as deemed necessary by the counselor and/or minor client.

Clinical Records: Communication between client and counselor becomes part of the clinical record. Once the counseling relationship ends, files are closed. Adult client records will be destroyed seven years after closing the file. Minor client records will be destroyed seven years after the minor turns 18 years of age. If you would like to request a copy of your records you must make request in writing to your counselor who has up to 15 days to produce a copy (at a cost of $.50/page). You have a right to request an electronic copy of records contained in electronic form. Please see the Texas Health and Safety Code, Title 7, Subtitle E, Chapter 611 for more information on records request.

Counselor Incapacitation: In the event your counselor is unable to provide ongoing services, records will be transferred to another counselor who will be responsible for contacting you and providing an appropriate referral.

Scheduling and Cancellations: Appointments may be scheduled on a weekly or bi-weekly basis and last 45-50 minutes. If you must cancel or reschedule an appointment call your counselor 24 hours in advance. If you fail to cancel or reschedule your appointment 24 hours in advance, you will be charged a $30 late fee. If you fail to show for a scheduled appointment you will be charged a $30 no-show fee. Insurance will not pay for missed appointments. Credit Card on File will be used to charge fees and remaining balances. Exceptions may be made to this policy in case of serious emergencies.

Fee Schedule		
	Initial Session	$120.00
	55 – 60 Minute Session (Individual, Couples, Family)	$120.00
	90 Minute Group Session	$ 30.00
	Late Cancellation Fee (less than 24 hours)	$ 30.00
	No-Show Fee	$ 30.00
	Return Check Fee	$ 25.00
	Paper Copy Fee	$ 0.50/per page
	Mandated legal proceedings*	$200/hour, .45/mile, $700 retainer

***Legal Proceedings:** Please be advised that your counselor DOES NOT participate in legal proceedings or disability assessments. If you are in need of such services, please discuss this with your counselor so an appropriate referral may be made. If your counselor is mandated by the court to participate in legal proceedings, an hourly rate of $200 will be charged for preparation and court time. Travel is billed at .45/mile. A $700 retainer will be due prior to the court date.

Emergency Contacts and Crisis Situations: Your counselor will establish emergency contacts for you (i.e. phone number, and location of a family member). Your counselor will also obtain alternative methods for contacting you (i.e. mobile or work number). These emergency contacts may be used if the counselor perceives a need.

We **do not** provide 24 hour crisis stabilization services. If you are in crisis contact emergency services (911) or immediately go to your nearest emergency room. You may also contact the Center for Health Care Services hotline 210-223-7233.

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HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW THIS NOTICE CAREFULLY.

COMMITMENT TO YOUR PRIVACY – We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession. “Protected health information” (PHI) includes any information which may identify you and relates to your past, present, or future physical or mental health or condition; the health care provided to you; and the past, present, or future payment for your health care. “Electronic health information” (EPHI) includes PHI created, stored, or transmitted electronically. This Notice of Privacy Practice describes the policies by which we may use and/or disclose your EPHI/PHI in accordance with applicable law. Additionally, it describes your rights about gaining access and control of your EPHI/PHI. We are required by law to protect the privacy of your EPHI/PHI and to provide notice of our legal duties and privacy practices concerning your EPHI/PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all EPHI/PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

USE OR DISCLOSURE FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The following categories describe the different ways in which we may use and disclose your EPHI/PHI:

- **Treatment:** We may use or disclose your EPHI/PHI to provide, manage or coordinate your care or related services. For example, we may use information about you to consult with other counselors and physicians, or refer you to another health care provider.
- **Payment:** We may use or disclose your EPHI/PHI to verify insurance coverage and/or benefits with your insurance carrier, to process your claims, to bill and collect payment for services and items you have received. For example, we may contact your insurance carrier to verify your benefits eligibility or we may disclose your EPHI/PHI to obtain payment from a third party, such as a family member, who pays for your insurance.
- **Healthcare Operations:** We may use or disclose your EPHI/PHI to perform activities related to the performance and operation of our practice. Examples may include, but are not limited to: certification, compliance and licensing requirements; reminding you of appointments; providing you with information about treatment alternatives or other health related benefits and services; communicating with a family member, a relative, a close friend, or any other person you identify as having involvement in your care.

USES OR DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION

We may use or disclose your EPHI/PHI when it is required by state or federal law. For example, but not limited to:

- **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.
- **Abuse of the Elderly and Disabled:** 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 Department of Protective and Regulatory Services.
- **Regulatory Oversight:** If a complaint is filed against a counselor with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.
- **Judicial or Administrative Proceedings:** We may use and disclose your EPHI/PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. In certain circumstances, we may also disclose your EPHI/PHI in response to a discovery request, subpoena, or other lawful process.
- **Serious Threat to Health or Safety:** We may use or disclose your EPHI/PHI to medical or law enforcement personnel if you or others are in danger and the information is necessary to prevent physical harm.
- **Workers’ Compensation:** We may use or disclose your EPHI/PHI to your employer’s insurance carrier if you file a worker’s compensation claim.
- **Law Enforcement:** We may use or disclose your EPHI/PHI for law enforcement purposes in order to comply with state and federal laws.
- **The Secretary of Health and Human Services**: We are required to disclose your EPHI/PHI to the United States Department of Health and Human Services when requested in order to enforce the privacy laws.
- **Counselor Incapacitation**: In the event your counselor is unable to provide ongoing services, your records will be transferred to another counselor who will be responsible for contacting you and providing an appropriate referral.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

- **Authorization for Other Uses and Disclosures**: Other use and disclosure of your EPHI/PHI not specifically permitted by state and federal law will be made only with your written authorization, which may be revoked by you at any time in writing. With some exceptions, we must obtain an authorization for use or disclosure of psychotherapy notes. "Psychotherapy notes" are notes made about our conversation regarding a private, group, joint, or family counseling session.
- **Marketing Uses of PHI**: In general, PHI cannot be used or shared for marketing without your authorization.
- **Highly Confidential Information:** Special privacy protections by state and federal regulations may apply for certain highly confidential information such as information about alcohol and drug abuse.
- **Texas Law:** Certain provisions of Texas Law may be more stringent than HIPAA. If such provisions are more stringent than HIPAA, Texas Law will take precedence.

CLIENT RIGHTS

- **Right to Receive Confidential Information:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may not want a family member to know you are seeking or receiving counseling services. Upon your request, we can send correspondence to an alternate address or leave messages through an alternate phone number.
- **Electronic database storage systems:** We utilize an electronic database system to store some of your EPHI/PHI. Should a breach in security occur, we will conduct an investigation following federal and state guidelines to determine if notification is required. You will be notified within 60 days if notification is required.
- **Inspection and Copies:** You have the right to inspect and obtain a copy of the EPHI/PHI that may be used to make decisions about you, including client medical records and billing records. Some exceptions may apply. Your right to inspect and copy EPHI/PHI may be restricted in certain circumstances; however, in some cases you may have this decision reviewed. If you ask for a copy of any information, you may be charged a reasonable fee for the costs of copying, mailing, and supplies.
- **Right to an Electronic Copy of PHI:** Massey Counseling creates, stores, and transmits some PHI electronically. You have a right to obtain an electronic copy of your PHI within 15 days of your request.
- **Right to Amend:** If you feel your health information is incorrect or incomplete, you may ask that we add information to amend the record. We are not required to agree to the amendment. We must notify you in writing of denial. You may submit a statement of disagreement which will be added to your file.
- **Right to an Accounting of Disclosures:** You have the right to request an accounting of certain disclosures made of your EPHI/PHI for purposes other than for treatment, payment, healthcare operations and certain other activities for six years prior to the request. We will provide one free accounting per year. You may be charged a reasonable fee for additional accounting requests.
- **Right to Request Restrictions:** You have the right to ask for restrictions on certain uses and disclosures of your health information. We are not required to agree to your request. If you pay for counseling services out of pocket, you have a right to have EPHI/PHI regarding such services held confidentially and not released to third parties (fully paid for by you with no reimbursement or additional payment by a third party).
- **Right to a Paper Copy:** You have the right to obtain a paper copy of this Notice of Privacy Practices from us upon request, even if you have agreed to receive the notice electronically.
- **Right to receive Changes in Policy:** You have the right to receive any future policy changes secondary to changes in state and federal laws.
- **Right to Complain:** If you believe your privacy rights have been violated, please contact your counselor personally and discuss your concerns. If you are not satisfied with the outcome, you may file a complaint with the U.S. Dept. of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201, (877) 696-6775 or on the Texas Attorney General's website (www.oag.state.tx.us). An individual will not be retaliated against for filing such a complaint.

THIS NOTICE WAS PUBLISHED AND BECAME EFFECTIVE ON JUNE 1, 2013

THIS NOTICE WAS REVISED ON 9/12/2013

Yvette Massey, MA, LPC, CST 210-887-1670 ymassey@mc.hush.com
LIC# 67634 NPI# 1508200247
19206 Huebner, Suite 104, San Antonio, TX 78258

RECEIPT & ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information (PHI). I understand this information can and will be used as follows:

- To provide, manage, or coordinate my treatment and follow-up care among healthcare providers who may be involved in that treatment directly and/or indirectly
- To obtain payment from third-party payers
- To conduct normal healthcare operations

I acknowledge I have received and/or read your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand you have the right to change your *Notice of Privacy Practices* from time to time, and I may contact you at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you may not be required to agree to my requested restrictions unless such restriction is specified by state or federal law. If you do agree, you are bound to abide by such restrictions. I understand that if I have any questions I may contact you.

_____________________________ _____________________________ ________________
Client's Name Signature Date

_____________________________ _____________________________ ________________
Client's Name Signature Date

WORK AGREEMENT

It is agreed that client(s) shall engage in the counseling process as an important priority in their life. Suspension, termination, or referral shall be discussed between counselor/client(s) for a pattern of behavior showing disinterest, lack of commitment, or for any unresolved conflict or impasse between counselor/client(s).

Service Fees: Payment is due at the time of your scheduled session. Any insurance co-pays or deductibles are due at the time of the session. Payment can be made in cash, check, or credit card. We cannot extend credit or provide services until payment is made. Clients understand they are fully responsible for all fees if for any reason insurance or other vendor does not pay.

We, the counselor and client(s), have read and fully understand and agree to honor this agreement. We have also agreed to an initial definition of work and to the fee to be paid by the client. I (we) also acknowledge that I (we) have received a copy of the Consent and Services Agreement.

Client's Name __________________________Signature______________________________ Date____________

Client's Name __________________________Signature______________________________ Date____________

Counselor's Signature____ Date____________

MINOR CLIENTS: I attest that I have the legal authority to seek and grant permission for counseling services for the minor(s) listed above. In the case of legal separation or divorce, I attest that I have the legal decree in my possession. A copy of the legal decree will be provided to the counselor before counseling can begin.

_____________________________ _____________________________ ________________
Name of Parent/Legal Guardian Signature Date

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Client Email/Texting Informed Consent Form

Risk of using email/texting – The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

1. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
2. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
3. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
4. Employers and online services have a right to inspect emails sent through their company systems.
5. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
6. Email and texts can be used as evidence in court.
7. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the use of email and texts – Counselor cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Your Counselor is not liable for improper disclosure of confidential information that is not caused by her/his intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

1. Email and texting is not appropriate for urgent or emergency situations. Counselor cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
2. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
3. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
4. Counselor will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
5. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
6. Counselor is not liable for breaches of confidentiality caused by the client or any third party.
7. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Counselor may impose to communicate with me by email or text.

______________________	______________________	____________
Client's Name	Signature	Date
______________________	______________________	____________
Client's Name	Signature	Date
______________________	______________________	____________
Name of Parent/Legal Guardian	Signature	Date

____ ____________
Counselor's Signature Date

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APPOINTMENT REMINDERS AND ONLINE APPOINTMENT SCHEDULING

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments. You can also enjoy the convenience of online scheduling at any time.

Once your account is established, you may visit **www.masseyy.weebly.com** to schedule or reschedule your appointments.

Requested Login Name	**Temporary Password**
|__|__|__|__|__|__|__|__|__|__|	|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)	**(letters or numbers only, must have at least 8 characters)**

Where would you like to receive appointment reminders? (check one)

_____ Via text message to cell phone number: _____________________(Normal text message rates will apply)

_____ Via email message to this address: ____

_____ Via automated telephone message to home phone:____

_____ None of the above. I'll remember my appointments on my own.

Acknowledgement and Consent

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above. I also understand that missed appointment fees will still apply.

______________________	______________________	______________
Client's Name	Signature	Date
______________________	______________________	______________
Client's Name	Signature	Date
______________________	______________________	______________
Name of Parent/Legal Guardian	Signature	Date
______________________		______________
Counselor's Signature		Date

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PRIMARY INSURANCE

Client Name: ____ Date of Birth: _____________

Responsible Party Name:_______________________________________ Date of Birth: _____________

Relationship to Client: ____________________ Employer:____________________________________

Home address if different from Client's:____

Home phone if different from Client's: ________________________ Ok to leave a message? ◯Yes ◯No

Cell/Other Phone:____________________________ Ok to leave a message? ◯Yes ◯No

Insurance Company Name or Mental Health Network:____

Mental Health/Customer Service Phone:____________________

Member ID Number:__________________ Group Number:________________ Effective Date:_______

Signature on File Authorization

I request that payment of authorized Medical/Behavioral Health benefits be made either to me or on my behalf to Massey Counseling, PLLC (Yvette Massey, MA, LPC), for services furnished to me by the provider. I authorize the release of any information relating to payment of claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature authorizes the provider to submit claims electronically for services rendered without my signature on every claim submitted for myself and/or my dependents.

_____________________________ _____________________________ _______________
Client's Name Signature Date

_____________________________ _____________________________ _______________
Client's Name Signature Date

_____________________________ _____________________________ _______________
Name of Parent/Legal Guardian Signature Date

____ _______________
Counselor's Signature Date

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CREDIT CARD AUTHORIZATION FORM

This credit card authorization form authorizes Yvette Massey, MA, LPC, CST to charge your credit card or debit card for any outstanding balances on your account. This credit card authorization form will be kept in your electronic file following HIPAA guidelines. You may pay for your sessions including co-payments, deductibles, or any amount that is not covered by your insurance with whichever method you choose. However, your credit card or debit card will be charged automatically for sessions that are rescheduled or cancelled with less than 24 hour notice, missed sessions, and for any outstanding balances that are not paid within 30 days of receiving a billing statement.

PHONE OR EMAIL CANCELLATIONS TO: (210) 887-1670 ymassey@mc.hush.com

Client's Name:____
Last First Middle Initial

Cardholder's Name: ____
Last First Middle Initial

Credit Card Information: ◯ MasterCard ◯ Visa ◯ American Express

Card Number: ________________________________ Expiration Date: ____________CVV:_________

Billing Address: ____
Street No. Street Name City State Zip Code

Signature on File Authorization

I acknowledge that I have read the above conditions and terms and agree to comply with them. I do hereby authorize the practice of Yvette Massey, MA, LPC, CST to keep my credit card or debit card information (as indicated above) on file for payment and to initiate appropriate payment entries against the above-referenced credit card or debit card, as applicable, as amounts are owed by me. I understand and agree that these entries may be made to my credit card or debit card, as applicable, periodically to pay amounts owed by me (see above). I also agree to notify Yvette Massey, MA, LPC, CST if my credit card or debit card information changes for any reason. This authorization shall remain in effect until the end of my services with Yvette Massey, MA, LPC, CST. I acknowledge receipt of a copy of this authorization form.

________________________ __________________________ _____________
Cardholder's Name Signature Date

____ _____________
Counselor's Signature Date