



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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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 _____

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- | | | | | |
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| ___ Divorce/separation | ___ Finances | ___ Stress control | ___ Other addictions | ___ Eating disorder |
| ___ Being single | ___ God/Faith | ___ Fatigue | ___ Grief/loss | ___ Hopelessness |
| ___ Sexual issues | ___ Weight | ___ Self-Mutilation | ___ Loneliness | ___ Depression |
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Do you possess any of these virtues/strengths?

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| ___ Gratitude | ___ Forgiveness | ___ Humility | ___ Prudence | ___ Self-control |
| ___ Fairness | ___ Hope | ___ Humor | ___ Spirituality | ___ Wisdom |

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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 _____

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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



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.



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” (EHI) includes PHI created, stored, or transmitted electronically. This Notice of Privacy Practice describes the policies by which we may use and/or disclose your EHI/PHI in accordance with applicable law. Additionally, it describes your rights about gaining access and control of your EHI/PHI. We are required by law to protect the privacy of your EHI/PHI and to provide notice of our legal duties and privacy practices concerning your EHI/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 EHI/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 EHI/PHI:

- **Treatment:** We may use or disclose your EHI/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 EHI/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 EHI/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 EHI/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 EHI/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 EHI/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 EHI/PHI in response to a discovery request, subpoena, or other lawful process.
- **Serious Threat to Health or Safety:** We may use or disclose your EHI/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 EHI/PHI to your employer’s insurance carrier if you file a worker’s compensation claim.
- **Law Enforcement:** We may use or disclose your EHI/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 EHI/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



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



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

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.masseyv.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



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



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