Mina O'Connell, MA, MS, PLLC
Licensed Marriage and Family Therapist

Client Information

Name: _____

Address: _____
Street City State Zip

Birth Date: _____ Age: _____ Gender: ☐ Male ☐ Female

Social Security #: _____ Phone: _____
Any: Cell Home or Work

I authorize leaving messages: _____
Initials

Relationship Status: ☐ Married ☐ Separated ☐ Single
☐ Widowed ☐ Divorced ☐ Cohabitating ☐ Child

Spouse or Parent/Guardian Name: _____

Address: _____
Street City State Zip

Phone: _____ I authorize leaving messages: _____
Any: Cell Home or Work Initials

If client is under 18, other parent or guardian:

Name: _____

Phone: _____ Gender: ☐ Male ☐ Female
Any: Cell Home Work

Emergency Contact: _____
Name Phone Number

Who may I thank for the referral? _____

Insurance and Fee Information

Name of Insured or Person Responsible for Payment (if not client): _____ Relationship to Client: _____

Address (if different from above): _____

DOB of insured for filing: ___ /___/___

Insurance Company: _____ Phone: _____

Member ID #: _____ Plan/Group Number: _____

Insured's Employer: _____ Co-pay: _____

Client Contract: I (client, responsible party) agree to the terms of this contract by acknowledging services rendered, and understand I am responsible for all payments. This includes co-pays, deductibles, session fees, court or consultation fees, telephone consults, testimony, cancellation fees, reports, collection costs, and any legal fees required for this account. Responsible party must pay, at the time services are rendered, to the receptionist or therapist, for self-payment or insurance co-payment by:

Cash ☐ Check ☐ ($25 returned check fee) Credit Card ☐

Fee Information: The therapy fee is based on a fifty (50) minute session and is $120 for the initial intake session and $100 for following sessions, unless otherwise specified. Clarify your mental health insurance benefits in terms of coverage and co-pays.

Cancelled/Missed Appointments: Please cancel with 24 hours of notice to avoid a $30 missed session fee. **I understand and will abide by this agreement. (initial)** _____

Telephone Calls and Emergencies: If you need to speak with me between scheduled sessions, please call during regular business hours, unless it is an emergency. Please indicate if your message is urgent requiring immediate contact. If unable to reach me, please call 911 or go to your nearest medical emergency facility. If I am available, conversations beyond ten minutes, crisis intervention, report writing, and extended coordination with other professionals will be billed at $2 per minute. I have informed you of this billing prior to the event. Legal involvement will be billed at $4 per minute, including preparation, report writing, and travel time. Retainers apply.

Termination: Our final session or 60 days after last communication will constitute termination.

Authorization to Pay Benefits and Release Information: I authorize this office to release information required to obtain assignment of benefits for services rendered or for legal or collection matters. I authorize payment for outstanding sessions to be made directly to my provider.

Signature of Client/Responsible Party: _____ Date: _____

Signature of Provider: _____ Date: _____

Office use only – Name: _____

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 IT CAREFULLY. Please review the full description of my Privacy Practices in the attached Office Policies and/or take a copy from the waiting room notebook.

Your Health Information Is Protected by Federal Law

Our office has set guidelines in compliance with the health insurance portability and accountability act (HIPAA), which gives you rights over all forms of your protected health information, whether electronic, written, or oral. Your records are confidential and may only be used for the following purposes: **treatment, payment, and health care operations**. You may ask that records not be shared, but disclosure may occur, only if needed, to the following types of recipients:

- Primary care physicians, psychiatrists, or health care providers
- Medical specialists
- Diagnostic facilities
- Hospitals or labs
- Insurance or EAP companies
- Quality control specialists and legal consultants
- Billing, claims, or collections personnel
- Emergency situation personnel

In addition, certain other disclosures do not require consent, pertaining to:

- Parent or legal guardian access to minor records
- Harm to self or others and public health concerns
- Child or vulnerable adult abuse
- Prenatal exposure to controlled substances
- Compliance with federal, state, or local laws, such as for Workers' Compensation
- Court proceedings
- Lawfully issued search warrants

Your written authorization to release most other types of records or communications will specify sender and recipient of personal data, and dates to begin and end disclosure. You may review and revoke releases of information at any time. You may ask to amend your information. You may receive communications at the location and by the means you wish.

You May Access Your Records

A copy of records may be received unless it is determined that disclosure might be harmful to self or others. Records will be given within 15 days for a copying fee. Records may be stored in written and electronic form for the required period. If you believe your privacy rights have been violated, you have the right to complain to Mina O'Connell, (210) 995-8968 or to Jorge Lozano, Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202, Voice Phone (800) 368-1019, FAX (214) 767-0432, TDD (800) 537-7697.

I have received the full Notice of Privacy Practices and have had the chance to ask questions about it.

_____/_____/_____/_____ _____

Name(s) Date

Office use only – Name: _____

Disclosure Statement

Is this form understandable? ☐Yes ☐No If you need help with this, please let me know.

Degrees: M.S. in Marriage and Family Therapy, Texas Woman's University, 1988
Thesis: *A Comparison of Self-Help and Systems Family Therapy for the Treatment of Bulimia*
M.A. in Biblical Studies with emphasis in Counseling, Dallas Theological Seminary, Texas, 1984

Licensure: State of Texas, Marriage and Family Therapy, number 201680

Memberships: Clinical Fellow in the American Association for Marriage and Family Therapy
Member of San Antonio Association for Marriage and Family Therapy
Member of Alamo Chapter of Texas Association for Play Therapy

Confidentiality

In general, all of your client information is private, except for the exclusions mentioned in the Privacy Notice. From time to time, I may consult with colleagues, without disclosing personal identifying information, to improve care and treatment. Identifiable information will only be released with your signed authorization. No session recording is allowed without all parties' consent.

Psychotherapy Process

Marriage and family therapy is an inexact science, and I cannot guarantee a cure. With hard work much progress may be made, however, this will depend upon the focused efforts of both therapist and client. Clinical research has demonstrated that marital and family conflict, child conduct problems, adolescent drug abuse, mood disorders, alcohol abuse, eating disorders, and dementia can be effectively treated with marriage and family therapy. Improvements in relationships, work, emotional and physical health, and community involvement may result. Satisfaction with treatment is likely. Generally, therapy is brief and focused with a short length of treatment, depending on the efforts applied. Although I am contracted with provider networks, they cannot be held responsible for your therapy experience or results. I am trained in a family systems perspective which may bring out different viewpoints on a life situation. This could cause discomfort along with growth and development. If progress is not being made, it is ethical to refer. Sexual intimacy is never appropriate in a therapy relationship, and must be reported to the board designated below. Involved personal relationships are not allowed when there is a professional therapy relationship.

Regulation of Psychotherapists

The Texas State Board of Examiners of Marriage and Family Therapists governs Marriage and Family Therapists. An individual who wishes to file a complaint against a Licensed Marriage and Family Therapist may write to Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369 or call 1-800-942-5540.

Christian Counseling

I offer Christian Counseling for those who desire this perspective on life's stages and difficulties, which may include prayer and Scripture. Is this something you are interested in? ☐ Yes ☐ No

Authorization for Treatment

I have read and agree to the above policies and to receive evaluation, treatment and/or referral under these conditions.

Signature of client, guardian, other family members: _____ /_____

_____ /_____ /_____ Date: _____

Signature of witness: _____ Date: _____

Office use only – Name: _____

Medical Information

Medical events over the past two years: _____

_____

Current medications prescribed and over the counter/dosage: _____

_____

Allergies: _____

Family Doctor: _____ Phone: _____ (if contact requested)

Psychiatrist: _____ Phone: _____ (if contact requested)

Tobacco use: Cigarettes ☐ Chewing ☐ Other ☐ How much? _____

Alcohol use: _____ Frequency: _____ How much? _____

Family history of alcohol and drug use/abuse, mental health, physical conditions: _____

_____

Any alcohol or drug usage during pregnancy? ☐ no ☐ yes What?: _____

Unusual or problematic occurrences during pregnancy? ☐ no ☐ yes During delivery: ☐ no ☐ yes

Congenital defects: ☐ no ☐ yes What, if any of the above? : _____

Age when first: Sat up _____ Crawled _____ Stood alone _____ Walked _____ Talked _____

Age when potty trained: ___ How long did it take to potty train? _____ Bedwetting/soiling? ☐ no ☐ yes

Any history of seizures, prolonged high fevers, head injuries, being dropped, poisoning, serious illness or injury?
_____

Any history of prolonged separations or traumatic events in childhood? _____

School and grade: _____/_____ Performance: _____

Problems/special services/IEP: _____

Office use only – Name: _____

I, _____ AUTHORIZE: Mina O'Connell, LMFT
4230 Gardendale, Bldg. 601
San Antonio, TX 78229

TO TRANSMIT PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

•Information related to the scheduling of meetings or other appointments
•Information related to billing and payment
•Short communications
•Questionnaires and assessments

BY THE FOLLOWING NON-SECURE MEDIA:

•Unsecured email _____ Email: _____
•SMS text messaging (traditional) _____ _____
•Phone ____ Email(s) of other persons

TERMINATION

This authorization will terminate 1 year after the date listed below or when the following event occurs: _____

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

I understand that Mina O'Connell makes available to me the following means of communication that are designed to be secure, and I still choose to authorize to the above named means:

•Encrypted texting through the free Qliq Connect app
•Encrypted email through Hushmail

_____/_____/_____ _____
Signature of client(s) Date