Michael Hack, LCSW, SAP
Corporate Family Counseling, PLLC
2717 Commercial Center Blvd
Suite E-200
Katy, TX 77494

REGISTRATION FORM

Name:_____

Home Phone:_____ **Cell Phone:**_____

Email:_____ **Work Phone:**_____

Home Address:_____

City:_____ **State:**_____ **Zip:**_____

_____**Male** _____**Female** **Birth Date:**_____ **Age:**_____ **SS#:**_____

Employer:_____ **Occupation:**_____

Relationship Status: ____**Single**____**Married**____**Widowed** __**Separated**___**Divorced** ____**Living with partner**

Spouse/Partner's Name_____

Whom may we thank for referring you?_____

In case of emergency, who should be notified?_____ **Phone:**_____

Any contact restrictions:_____

Please check any/all preferred methods of appointment reminder:

____**Phone** ____**Text** ____**E-mail** **Do not contact by** _____

Other than myself, _____**is given the right to receive information or make my appointments.**

CANCELLATION POLICY

Cancellation of an appointment requires 48 hours notification. Late cancellations will be charged at full fee, directly to the patient or client. A signature below indicates that you understand and accept these conditions.

Credit Card Type (ie: Debit, Health Savings, Matercard, Visa, Discover, etc: _____

Credit Card # for our confidential files: _____

Expiration date: _ _/ _ _ **Security Code #:** _ _ _ **Billing Zip Code:** _ _ _ _ _

NOTICE OF PRIVACY PRACTICES

I have received a copy of Michael Hack, LCSW, SAP, Notice of Privacy Act Policies and I have been provided an opportunity to review it. I understand that as part of my care, Michael Hack, LCSW, SAP originated and will maintain paper and/or electronic records describing my history, symptoms, diagnosis, mental health treatment, business coaching, and any plans for future counseling. I understand this notice and I request the following restriction (s) concerning the use of my personal information: _____

_____ _____

Signature **Date**

Michael Hack, LCSW, SAP
Corporate Family Counseling, PLLC
2717 Commercial Center Blvd
Suite E-200
Katy, TX 77494

INFORMED CONSENT FOR PSYCHOTHERAPY SERVICES

Confidentiality:
All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure are described in the HIPAA Notice of Privacy Practices.

Preventing Harm: Disclosure is required by law in situations in which (1) there is a reasonable suspicion of child, dependent or elder, abuse or neglect; and (2) a client presents a danger to self, to others, to property, or is gravely disabled**.** If there is an incident during or after the course of treatment in which your therapist becomes concerned about your safety or the possibility of your harming another, he will take reasonable measures within the limits of the law to ensure the safety of yourself and others. For this purpose, he may also contact the person whose name you have listed as an emergency contact.

Legal Proceedings & Litigation Limitation: Disclosure *may* be required pursuant to a legal proceeding. (For example, if you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your therapist.) Due to the private nature of psychotherapy, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you, your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Family Involvement: In couples and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Your therapist will not release records to an outside party unless she is authorized to do so by all adult family members who were part of the treatment.

Confidentiality of E-mail, Cell Phone and Fax Communications: E-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication cannot be guaranteed.

Consultation: Your therapist may consult with other professionals regarding his clients; however, the clients name or other identifying information is never mentioned. The clients identity remains completely anonymous, and confidentiality is fully maintained.

Chance Encounters: Given that Katy, Texas is a relatively small community, you may encounter someone you know in the waiting room or cross paths with your therapist out in the community. Your therapist will never acknowledge working with you therapeutically to anyone without your written permission. If you see your therapist in a public place, he will acknowledge you only if you initiate the interaction, so as to maintain your confidentiality. Please respect the privacy of other clients you may recognize in the waiting room or outside the office by not sharing with others your knowledge of their therapy participation.

The Therapy Process:
Your therapist utilizes therapy approaches that involve collaboration. Your active participation is a pivotal factor in your progress. Effective participation on the part of the client includes expressing yourself honestly, being open to feedback, questioning ideas that you disagree with or do not understand, and implementing new strategies discussed in therapy. It is your therapists responsibility to listen carefully to you, share his observations, share his observations and insights related to your situation, and provide education on current perspectives from psychology research and practice, and connect you with additional resources that may be helpful (such as books, support groups, etc.). Your therapist will collaborate with you at the end of each session to design "homework" assignment(s) to further the work begun in your therapy sessions. This is a key component of the therapy process, and your progress will reflect how actively you implement new strategies during time between sessions.

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, your therapist will discuss with you his working understanding of the problem, treatment plan, therapeutic objectives, and his view of the possible outcomes of treatment. Your therapist will answer any questions you may have about procedures used in the course of your therapy, his expertise in employing them, or their possible risks. You may also ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that your therapist does not provide, he has an ethical obligation to assist you in obtaining those treatments. During the course of therapy, your therapist is likely to draw on various psychological approaches based on his expertise and his assessment of what will best benefit you. A variety of approaches may be incorporated.

Michael Hack, LCSW, SAP
Corporate Family Counseling, PLLC
2717 Commercial Center Blvd
Suite E-200
Katy, TX 77494

Outcomes: There is no guarantee that psychotherapy will yield positive or intended results. Change will sometimes be easy and swift, but other times it may seem slow and even frustrating. During therapy, exploring unpleasant events, feelings, or thoughts can result in your experiencing considerable negative reactions such as anger, sadness, worry, fear, anxiety, depression, and insomnia. Such reactions should be discussed with your therapist and monitored closely. Progress should be assessed and treatment goals established by mutual consent. If adequate progress is not seen, you and your therapist should discuss the treatment process and evaluate whether a different direction should be considered.

Ending Therapy: If at any time during treatment your therapist assesses that he cannot be effective in helping you reach your therapeutic goals, he will provide multiple referrals to resources that may be of help to you. If you wish, he will talk to the psychotherapist of your choice in order to help with the transition. If at any time you wish to consult with another therapist, your current therapist can assist you in finding someone else who is also qualified. You have the right to end therapy at any time. It is strongly advised that you discuss ending treatment with your therapist before doing so, in order to process the transition in the most effective way possible. At the close of therapy, your therapist will offer to provide you referrals for additional resources for continuing personal development.

Telephone & Emergency Coverage:
If you need to contact Michael Hack, LCSW in between sessions please call: +1-832-529-6001. Your call will be returned as soon as possible. Voice messages will be retrieved continually. For emergencies, call 911. When your therapist is out of town, coverage by another therapist will be arranged.

Payments & insurance Reimbursement:
Clients are expected to pay the standard initial Biological, Psychological, Social Inventory & Assessment fee of $350. Subsequent session fees of $250 per session are required in advance, unless other arrangements have been made. Services provided outside of these sessions (e.g., telephone conversations, report writing, consultation with other professionals) will be charged at the same rate if such charges are agreed upon in advance by therapist and client. If you intend to utilize your health insurance, remember that professional services are rendered and charged to the client and not to the insurance companies. Your therapist can provide you with a monthly medical invoice, which you may then submit to your insurance company for reimbursement. Not all issues which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage for out-of-network providers.

Appointment Cancellation:
Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hour's notice is required for rescheduling or canceling an appointment. Clients are responsible for paying the session fee for missed sessions or late cancellations. Exceptions may of course be granted for emergency situations.

Please initial each of the following statements to indicate your agreement and print/sign your name below.

_____ I have read the above Informed Consent Agreement and agree to comply with its terms.

_____ I understand that I am responsible to pay for missed sessions that are not cancelled with at least 48 hours' notice and that insurance companies do not reimburse for missed sessions.

_____I have received the Health Insurance Portability and Accountability Act (HIPAA) notice and I consent to the use or disclosure of my Protected Health Information as specified.

_____
Client name (print)

Date:

_____
Signature

_____

Michael Hack, LCSW, SAP
Corporate Family Counseling, PLLC
2717 Commercial Center Blvd
Suite E-200
Katy, TX 77494

Consent for Release of Confidential Information

I, _____, authorize Michael Hack, LCSW

to release to _____ the following information:

_____ Intake Evaluation/Assessment

_____ Consultation information

_____ Progress Notes

_____ Psychological Testing and/or Reports

_____ Other _____

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire (60) days after the date of patient discharge, unless another date is specified.

Specification of the date, event or condition upon which this consent expires:

To the Party Receiving this Information:

This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Signature: _____ Date: _____

Witness Signature of Parent of Guardian (if under 18): _____

Corporate Family Counseling, PLLC
2717 Commercial Center Blvd
Suite E-200
Katy, TX 77494

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.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at: Corporate Family Counseling, PLLC at 2717 Commercial Center Blvd. Katy, TX 77494

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Corporate Family Counseling, PLLC at 2717 Commercial Center Blvd. Katy, TX 77494 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.