

Darian M. Gilchrist, LPC-Associate
Licensed Professional Counselor, Associate

100 Chestnut St suite 101
Abilene, Texas 79602



POLICIES & PROCEDURES
Please Read Carefully!

FEE SCHEDULE

The usual fee for sessions is \$40.00 an hour. Longer or shorter sessions are prorated from this basic fee.

Fees for court appearance, whether you or your attorney requests it, or if I am subpoenaed, are \$100.00 per hour. You will be responsible for all my time; including time for driving to court, waiting to testify, giving testimony, as well as preparation and/or research time that is required. Payment is required in advance.

PAYMENT METHOD

Payment is requested before your session begins and may be made by cash or Credit Card.

MISSED APPOINTMENTS AND LATE CANCELLATIONS

If you are unable to keep an appointment, please notify us immediately. If you do not call at least 24 hours before the appointment, you will be charged for the entire session.

RESPONSIBILITY

The client (or referring parent in the case of minors) is considered responsible for payment of professional services. In the case of divorced parents, we ask the parent bringing the child to pay the fees and then they be reimbursed by the parent not present. If there is ever a failure to pay an outstanding balance, we reserve the right to employ a collection agency and furnish them with information in order to collect.

You are encouraged to ask any questions you may have at any time including before you sign this form. Your signature below indicates that you understand and will comply with the above policies and procedures of Texas Family Institute. **Anyone age eighteen or older who participates in therapy needs to sign below:**

Signature: _____

Date: _____

Agreed upon fee: _____

I will pay today by: Cash Credit/Debit

CONFIDENTIALITY

Your right to confidentiality is protected by federal regulations and rules and regulations of the therapist's professional licensing boards. What you and the counselor discuss is strictly private unless you sign a Release of Information form asking us to disclose specific information to another individual or authority.

There are exceptions to this policy. Confidentiality may be broken and the appropriate individuals or authorities notified if:

1. I learn that you are a serious threat to yourself or others; or
2. I learn that a child or elderly person has been abused in the past or suspect that a child or elderly person may be abused in the future; or
3. A federal or state court brings a case to the judicial system concerning a client.

The above situations rarely happen, but it is important that you understand your rights to privacy and the limits of those rights. If you have any questions regarding this policy, please ask your counselor.

I have read and understand the above statement:

Signature

Date

Policy for missed appointments and late cancellations

I am honored to work with you and your family. Because I want to have a schedule that works for you and for me, I ask that we agree on the following:

- We will give each other at least 24 hours' notice if an appointment needs to be changed. This allows either one of us to make other arrangements for work and child care. It protects our relationship from frustration over appointment times.
- If an appointment needs to be cancelled with less than 24 hours' notice, please pay your copay or the agreed upon fee for the session (If you do not have a copay, please pay a \$25 cancellation fee). This covers our office expenses for appointments that are missed.
- After the second appointment missed with less than 24 hours' notice, your name will be placed on a list to be called when appointments become available, typically on short notice.

I value your time and appreciate your consideration.

Signed _____

Date _____

CLIENT REGISTRATION INFORMATION

DATE OF FIRST VISIT: _____

LAST NAME: _____ FIRST (OR PREFERRED): _____

DATE OF BIRTH: _____ Sex (F/M): _____ MARITAL STATUS: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

	May Call:	May Leave Message:
CELL PHONE(S): _____	Y / N	Y / N
_____	Y / N	Y / N
HOME PHONE: _____	Y / N	Y / N
WORK PHONE: _____	Y / N	Y / N

Please indicate which number is the primary number: CELL ___ HOME ___ WORK ___

OTHER FAMILY MEMBERS LIVING AT HOME

NAME	DATE OF BIRTH	RELATIONSHIP (to you)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMERGENCY CONTACT: _____
Name Phone Number

Address City State Zip

WHO REFERRED YOU TO OUR OFFICE? _____

(CONTINUED ON NEXT PAGE)

Personal Physician _____ Office Number _____

Please list any medications you are currently taking:

Name	Reason	Dosage	Frequency	From → To

Which doctor is prescribing these medications? _____

Do we have permission to contact your doctor for consultation regarding your medications and counseling progress? Yes No

List current medical conditions (not referred to above):

List past medical conditions including hospitalizations:

Have you ever received psychiatric or psychological help or counseling of any kind before? Yes / No
If you have, please explain (include dates, diagnosis, goals, and response to treatment):

Briefly describe your reason(s) for seeking help:

Please give marital history: (if applicable)

1st marriage: Years _____ children & ages _____

2nd marriage: Years _____ children & ages _____

3rd marriage: Years _____ children & ages _____

Briefly describe your current marital relationship: (if applicable)



**CLIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION
(Permission to Treat)
Darian M Gilchrist, LPC- Associate**

I, _____,
Name of Client

hereby give my consent for Darian M Gilchrist, LPC-Associate to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPO). By signing this form, I agree to let you use and disclose my information to carry out my treatment and/or arrange for payment of treatment.

The Notice of Privacy Practices explains in more detail how you can use and disclose my information. I have the right to review the NPP prior to signing this document. Please read it before you sign below.

I may request that you restrict how you use and disclose my PHI to carry out my TPO; however, Darian M Gilchrist is not required to agree to my request, but if she does, it is bound by this agreement. I may revoke my consent (in writing) except to the extent that disclosures have already been made in reliance on my prior consent.

If I do not sign this consent form or later revoke it, Darian M Gilchrist may decline to provide treatment to me.

Darian M Gilchrist reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, Stephanie Paschal, at 100 Chestnut suite 101 Abilene, Texas 79602.

Signature of Client/Parent/Guardian

Date

Client's Name _____

Client's Date of Birth _____

Print Name of Client/Parent/Guardian

_____ Copy Given to Client

Notice of Privacy Practices

Please review it carefully

This notice describes how medical information about you may be used and disclosed.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluation your health, diagnosing medical conditions and providing treatment. For example, results of tests will be available in your medical record to all health professionals who may provide treatment. Or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as insurers. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Healthcare Operations: Your health information may be used as necessary to support the day-to-day activities and management of Texas Family Institute counseling practice. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, to comply with mandated reporting and as court ordered.

Other Uses and Disclosures Require Your Authorization: Disclosures of your health information or its use for any purpose other than those listed above required your specific written authorization. If you change your mind after authorizing a use and disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Reminders: your health information will be used by our staff to provide appointment reminders.

Information about Treatment. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

Individual Rights: You have certain rights under the federal privacy standards. These Include:

- *The right to request restriction on the use and disclosure of your protected health information
- *The right to receive confidential communication concerning your medical condition and treatment.
- *The right to inspect and copy your protected health information.
- *The right to amend or submit corrections to your protected health information.
- *The right to receive an accounting of how and to whom your protected health information has been disclosed.
- *The right to receive a printed copy of this notice.

Texas Family Institute duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests To Inspect Protected Health Information: You may generally inspect your protected health information that we maintain about you. As permitted by federal regulation, any request to inspect protected health information must be submitted in writing. You may obtain a form to request access to your records by contacting: Stephanie Paschal. Your written request will be reviewed and will generally be approved, unless there are legal or medical reasons to deny the request. You will be timely notified.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you may do so by sending a letter outlining your concerns to Stephanie Paschal

If you believe that your privacy rights have been violated, you should call the complaint to our attention by sending a letter describing the cause of your concern to the same address. We make every effort to meet the requirements of the law. You will not be penalized or otherwise retaliated against by submitting a complaint. The name and address of our staff member you may contact for further information concerning our privacy practices is:

Stephanie Paschal
100 Chestnut suite 101
Abilene, TX 79602

I have received a copy of information pamphlet entitles "Notice of Privacy Practices" from Texas Family Institute

I have read or will read the information contained in this brochure concerning my health information, its uses and disclosure my rights as a client of this behavioral mental health counseling practice and the clinic's responsibilities. If I have any questions, I may address them with the manager of the practice.

I acknowledge the receipt of this information.

DATE

Client Signature

Staff Signature

Additional Demographic Information

Optional

(information to be used for grant opportunities)

Parent/Guardian: _____ Client: _____

Number of people living in home: _____ Number of Dependents: _____

Monthly Income per household: _____ Annual Income per Household: _____

Married: _____ Single: _____ Divorced: _____ Separated: _____ Primary Custodial Parent: _____

Employed: _____ Student: _____ Retired: _____ Disabled: _____

Ethnicity: _____ Race: _____

We want to thank you for providing this information. It is pure voluntary and any information gathered is to be used for grant opportunities to better assist the communities mental and behavioral health needs of Abilene and the surrounding areas residents. Providing this information could help us form classes / programs / groups / seminars/ workshops/.