NOTICE OF PRIVACY PRACTICES

(CONDENSED VERSION)

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.

OUR COMMITMENT TO YOUR PRIVACY
Our practice is dedicated to maintaining the privacy of your personal health information (PHI) as part of providing professional care. We are required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices.

HOW WE USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION WITH YOUR CONSENT
The information collected is used for the following: to provide treatment, arrange payment for services and all other business activities related to healthcare operations. If at any time your information is used for purposes other than those outlined, a separate authorization form will provided in effort to allow this.

DISCLOSING YOUR HEALTH INFORMATION WITHOUT YOUR CONSENT
Though our counseling sessions are private, there are limits to this confidentiality and legal issues that cannot go unreported. The following are Limits to our Confidentiality:
1. When there is a serious threat of harm to your or another's health and safety or public, this information will be used to help prevent or reduce the threat.
2. When we are required to do so by lawsuits or court related tasks.
3. For workers' compensation and similar benefit programs.
**Please see long version of privacy practices for further details.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION
1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records. These records are available for a fee.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above.

If you have any questions regarding this notice or our health information privacy policies, please contact Alisha Woodall at 214-782 9031.

INTAKE FORM

Please print legibly.

If you have been a patient here before, please fill in only the information that has changed.

DATE ....

A. CLIENT PROFILE

NAME .... DATE OF BIRTH ....

NICKNAMES/ALIASES

....

PHYSICAL ADDRESS

....
Street Address

....
City, State, Zip + 4 digit postal code

HOME/EVENING PHONE ....

EMAIL ....

PLEASE INDICATE ANY RESTRICTIONS:

....

B. REFERRAL

How did you hear about Finding the Foundation?

NAME .... PHONE ....

May I have your permission to thank this person for the referral? ◯ **YES** ◯ **NO**

(Continue on next page)

INTAKE FORM

Please print legibly.

C. RELIGIOUS AND RACIAL/ETHNIC IDENTIFICATION

CURRENT RELIGIOUS DENOMINATION/AFFILIATION:

○ **PROTESTANT** ○ **CATHOLIC** ○ **JEWISH** ○ **ISLAMIC** ○ **BUDDHIST**

○ **HINDU** ○ **OTHER** ....

INVOLVEMENT: ○ **NONE** ○ **SOME/IRREGULAR** ○ **ACTIVE**

How important are spiritual concerns in your life?

....

Which (if any) church, synagogue, temple, mosque or meeting are you involved with?

....

D. MEDICAL INFORMATION

CLINIC OR DOCTOR'S NAME

.... PHONE ....

ADDRESS ....

May I coordinate treatment with your Primary Care Physician? ○ **YES** ○ **NO**

If yes, consent form is required.

(Continue on next page)

INTAKE FORM

Please print legibly.

D. MEDICAL INFORMATION (CONTINUED)

Do you use alcohol or drugs? ○ **YES** ○ **NO**

Are you currently under the influence? ○ **YES** ○ **NO**

Are you suicidal? ○ **YES** ○ **NO**

Have you attempted suicide in the past 30 days? ○ **YES** ○ **NO**

If yes, please provide further details and information regarding treatment involved:

....

....

Please list all medications you are currently prescribed:

....

....

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

○ **NO**

○ **YES** Previous therapist/practicioner: ....

Date of last session: ....

Reason for therapist change: ....

(Continue on next page)

INTAKE FORM

Please print legibly.

E. EMPLOYMENT

EMPLOYER ....

ADDRESS ....

WORK PHONE ....

EMAIL ....

PLEASE INDICATE ANY COMMUNICATION RESTRICTIONS:

....

F. EMERGENCY

If an emergency arise and we need to reach someone close to you, whom should we call?

NAME ....

RELATIONSHIP ....

PHONE ....

ADDRESS ....

G. INSURANCE INFORMATION

INSURANCE PROVIDER .... PLAN ....

NAME OF ENROLLEE .... MEMBER ID ....

PROVIDER 800 # .... GROUP # ....

COPAY: .... # OF EAP SESSIONS ALLOWED: ....

AUTHORIZATION # ....

(Continue on next page)

INTAKE FORM

Please print legibly.

FAMILY HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

			RELATIONSHIP TO YOU
Alcohol/Substance Abuse Anxiety	◯ NO	◯ YES	....
Depression	◯ NO	◯ YES	....
Domestic Violence	◯ NO	◯ YES	....
Eating Disorders	◯ NO	◯ YES	....
Obesity	◯ NO	◯ YES	....
Schizophrenia	◯ NO	◯ YES	....
Suicide Attempts	◯ NO	◯ YES	....

Expectation of counceling services:

....

....

I acknowledge that the information provided is true and accurate. I understand the limits of confidentiality, cancellation policy as they have been explained.

....

Client Signature *Date*