BEAR CREEK COUNSELING CENTER
15430 Ridge Park Drive
Houston, TX 77095
Phone: 281-858-5874 / Fax: 281-858-5876
www.bearcreekcounseling.com

HOW DID YOU FIND OUT ABOUT BEAR CREEK COUNSELING CENTER?

Internet: □ BCCC Website □ Psychology Today □ Internet Search Engine: _____

□ Pastor: _____ □ Church: _____

□ School Counselor/Teacher: _____ □ Counselor/Therapist: _____

□ Physician _____ □ Other: _____

□ Sign/Drive By □ Neighborhood Newsletter: _____

Patient Information

Name of Patient: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

DOB: _____ / _____ / _____ Age: _____ SEX: _____ SS#: _____

Email: _____

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Employer: _____

Employer's Address: _____

Family Information

Name of Spouse or Parent: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

DOB: _____ / _____ / _____ Age: _____ SEX: _____ SS#: _____

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Employer: _____

Insured Information

Policy Holder's Name: _____ DOB: _____ / _____ / _____

Insurance Company: _____

ID #: _____ Group #: _____

Employer: _____ SS#: _____

Insurance Company Phone #: _____

Relationship to Patient: _____

Reason for appointment: _____

_____

BEAR CREEK COUNSELING CENTER

Office Policies and Procedures

This form provides information about our counseling relationship, procedures involved, and your authorized consent to treatment.

Length of Session: 45-50 minutes

Cost of Session: $165.00 _____ (patient initials)

Cancellations: Your session time is reserved for you and is taken seriously. Except for emergencies, cancellations must be made 24 hours in advance to avoid being charged. Monday appointments must be cancelled by the previous Friday. A charge of $85 will be made for missed appointments. A 24-hour voice-mail service is available 7 days a week, it is provided for your convenience at 281-858-5874.

Fee Structure: The client is financially responsible for payment of fees, which will be collected at the time of service. The client will also be responsible for any portion of fees not reimbursed or covered by health insurance. Additional cost may be incurred for use of assessment instruments. In the event of an accrued balance, the client and therapist can negotiate a payment schedule/plan.

Confidentiality: Information shared in session is held in the strictest of confidence according to federal law (regulation 42 CFT Part 2). Exceptions include: legal obligations (such as child abuse, elder abuse, testimony required by a judge, personal danger to self or an identifiable victim); information provided to parents if the client is a minor; and consultation with supervising professionals. Advice may be elicited from professional peers in regard to your case, without revealing your identity. Release of information to another professional may be done only with your written consent.

Counseling Approach: The client is held responsible for his/her feelings and behavior while focusing on the "problem" rather than the symptoms. Depending on the therapy issues, various family members may be requested to attend counseling sessions. Although regular attendance will produce the maximum benefits, no therapist can ethically guarantee achievement of goals. The client is encouraged to ask questions about the process during the course of therapy, and is free to discontinue therapy at any time. Because of the nature of the counseling process, the client may experience emotional strains, and may possibly make life changes that could be distressing.

Consent: The signature below confirms that the information has been read and discussed with the therapist, and I _____ accept the policies listed above. I hereby give fully informed consent to therapist Steve Hartman M.A., LPC to enter into a psychotherapy relationship with me.

_____ _____

Patient Name (PLEASE PRINT) Date of Birth

_____ _____

Patient Signature Date

_____ _____

Parent Signature, if Minor Date

BEAR CREEK COUNSELING CENTER

Confidentiality

PLEASE READ CAREFULLY

Generally speaking, communications between patient and mental health provider are confidential and may not be disclosed without your consent, or as otherwise provided by law.

There are exceptions to the general rule of confidentiality which would require that the mental health provider report his or her concerns without the consent of the patient. These occasions include, but are not limited to, the following:

- Belief that child abuse has or may occur
- Belief that an elderly or mentally handicapped person has been or may be abused
- Reports by a patient of possible sexual abuse or exploitation by a previous therapist
- Personal danger to self or an identifiable victim
- Testimony required by a judge
- Information provided to parents if the client is a minor
- Consultation with supervising professionals

Special rules apply to minors: By law, a parent has the right to the medical record of a child, unless this right has been limited to court action. Parents, on the other hand, may agree that during the course of treatment given to a minor child, they will waive the right to the medical record of their child. Such a waiver is helpful for useful clinical work with a minor.

Additionally, advice may be elicited from professional peers in regard to your case, without revealing your identity.

If you have any questions, or would like additional information please feel free to ask.

ACKNOWLEDGEMENT BY PATIENT

I have read the preceding and understand my rights as a patient.

Patient Signature: _____ Date: _____

I am willing to waive my right of access to communication between my child and their physician/therapist and grant to the physician/therapist the discretion to determine when or if such communication would be shared with me.

Parent Signature: _____ Date: _____

Patient Signature: _____ Date: _____

BEAR CREEK COUNSELING CENTER

Assignment of Benefits Authorization

I hereby authorize payment to Bear Creek Counseling Center for the medical benefits otherwise payable to me, but not to exceed therapist's charge. I understand that I am financially responsible for charges not covered by this authorization.

I hereby authorize Bear Creek Counseling Center to release to my insurance company any clinical information that is required to assist with the filing of my insurance claim. This may include any clinical options, diagnosis, treatment plan, and history information.

I further agree not to hold Steve Hartman, M.A., LPC or their associates liable for the disclosure of such clinical information, as it is at my request that such be provided. I also understand that my insurance company will be requesting detailed and specific historical information, and hereby authorize such release of such.

Benefit and authorization is a determination based upon medical necessity and is not a guarantee of claim payment. Payment determination will be made at the time a claim is received and will be based on eligibility, plan limits, plan exclusions, and overall plan language.

All insurance benefits verifications are subject to final payment from your insurance company and are not the responsibility of this office.

_____ _____

Patient Name (PLEASE PRINT) Date of Birth

_____ _____

Patient Signature Date

_____ _____

Parent Signature, if Minor Date

BEAR CREEK COUNSELING CENTER

Patient Information Regarding Professional Fees

I understand that payment is expected at the time of delivery of service. I authorize Steve Hartman, LPC or his authorized representative to charge my card.

I UNDERSTAND THAT I WILL BE CHARGED FOR MISSED APPOINTMENTS AND CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE. All cancellations should be CALLED into the office. Feel free to leave a message after hours and on weekends to avoid a late cancellation fee. Please be aware that insurance will not cover charges for missed appointments or late cancellations.

IT IS CLEAR THAT THE FINANCIAL RESPONSILIBILITY FOR SERVICES PROVIDED IS YOURS AND THAT INSURANCE IS FOR YOUR REIMBURSEMENT. I am not in-network with any insurance company.

I understand that if I am involved in any legal action that requires testimony or deposition, that Steve Hartman, LPC will charge a fee of $300 per hour portal to portal. This fee also includes time spent preparing for the testimony or deposition and making copies of any records involved. There will be a 3 hour minimum charge for any testimony or deposition.

I have provided Bear Creek Counseling Center with my credit card number and authorize them to keep my signature on file, and to charge my credit card account for all insurance payments paid directly to me that were due to this office; for all missed appointments and for all balances. I understand that this form is valid unless I cancel the authorization through written notice to this clinic.

We DO NOT accept American Express or Discover.

Patient's Name: _____

Billing Address: _____

Card Type: _____ Visa
_____ MasterCard

Charge Card Number: _____

Card Expiration Date: _____

Card Holders Name: _____

Card Holders Signature: X _____

Date: _____

BEAR CREEK COUNSELING CENTER

Current Medications for Medical and Psychiatric Conditions

Name of Medication	Current Dosage	Start Date	Side Effects
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No

I have read all information on this page, and have completed the above information. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____ _____

Patient Name (PLEASE PRINT) Date of Birth

_____ _____

Patient Signature Date

_____ _____

Parent Signature, if Minor Date

BEAR CREEK COUNSELING CENTER

Email and Texting Consent

You may give permission to Steve Hartman, LPC to communicate with you by email and text message (also known as SMS). This form provides information about how we use email/text communication. It also will be used to document your consent for communication with you by email and text message.

1. **How we will use email and text messaging:** We use these methods to communicate only about non-sensitive and non- urgent issues. All communications to or from you may be made part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. We will not disclose your emails or text messages to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.

2. **Conditions for the use of email and text messages:** Bear Creek Counseling Center staff cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. You must acknowledge and consent to the following conditions:

    a. **IN A MEDICAL EMERGENCY, DO NOT USE EMAIL, CALL 911.** Do not email for urgent problems. If you have an urgent problem during regular business hours, please call the office. Urgent messages or needs should be relayed to us by using regular telephone communication and may include text messages.
    b. Emails should not be time-sensitive. While we try to respond to email messages daily, call our office to follow up if we have received your email.
    c. You should speak with your therapist to discuss complex and/or sensitive situations rather than send email or text messages regarding such situations.
    d. Email and text messages may be filed electronically into your medical record.
    e. Clinical staff will not forward your identifiable email/texts to outside parties without your written consent, except as authorized by law.
    f. You should use your best judgement when considering the use of email or text messages for communication of sensitive medical information. Clinical staff are not responsible for the content of messages.
    g. Bear Creek Counseling Center and its staff are not liable for breaches of confidentiality caused by you or any third party.
    h. It is your responsibility to follow up with your therapist, if warranted.

3. **Withdrawal of consent:** I understand that I may revoke this consent at any time by so advising Bear Creek Counseling Center in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

4. **Client Acknowledgment and Agreement:** I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between Bear Creek Counseling Center staff and me and consent to the conditions and instructions outlined, as well as any other instructs Bear Creek Counseling Center may impose to communicate with me by email or text message.

_____ _____

Patient/Guardian Signature Print Name

_____ _____

Relationship to patient Date

BEAR CREEK COUNSELING CENTER

Permission to Obtain Services Via Skype/Face Time

You have requested to receive services via Skype/Face Time. These are downloadable internet software applications that allow users to transmit video streaming over the internet, via webcam: and/or share various kinds of files. To participate in this service, please provide the required permission and information on the form below:

Name of Patient: _____

Email: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

We take precautions to protect your privacy. However, since Skype/Face Time are public series, you need to be aware that sending information over the internet does include the risk of personal information being accidently disclosed to other people (i.e., on the web). For this reason, we need your permission to utilize our services via Skype/Face Time.

_____ Yes, I give my permission to utilize services via Skype/Face Time.

_____ No, I do not give my permission to utilize services via Skype/Face Time.

_____ _____

Patient/Guardian Signature Date

_____

Relationship to patient

BEAR CREEK COUNSELING CENTER

COVID-19 Patient Health Screening Form

This form must be completed prior to EVERY appointment with our office.

Patient Name: _____ Date of Birth: _____ Appointment Date: _____

In the past 14 days, have you traveled to a foreign country or been in close contact (within 6 feet) with a person who has returned from a foreign country within the past 14 days?

- ☐ Yes
- ☐ No

In the past 14 days, have you traveled outside of your hometown within the United States without following the recommendations or guidelines to prevent and control the spread of Coronavirus infection as established by the applicable authorities in the area in which you were traveling (e.g., wearing personal protective equipment such as facemasks and/or adhering to social distancing standards)?

- ☐ Yes
- ☐ No

Do you currently have (or have you had in the past 14 days) any of the following symptoms: Fever, Chills, Cough, Headache, Sore Throat, Congestion or Runny Nose, Nausea or Vomiting, Shortness of Breath or Difficulty Breathing, Loss of Smell or Taste, Unusual Fatigue, Diarrhea, Muscle or Body Aches?

- ☐ Yes
- ☐ No

In the past 14 days, have you been in contact (within six feet) of a person with possible Coronavirus or have you tested positive for Coronavirus (COVID-19)?

- ☐ Yes
- ☐ No

☐ **By checking this box and signing below, I affirm and certify that all the information and answers to questions herein are complete, true and correct to the best of my knowledge and belief.**

Patient Signature: _____ Todays Date: _____

For Office Use Only

Patient's Temperature: _____

BEAR CREEK COUNSELING CENTER

Receipt of Notice of Privacy Practices

(see last 2 pages)

Patient Name (PRINT): _____

Patient Date of Birth: _____

Given to Patient on: _____

Version/Effective Date: April 14, 2003

_____ _____

Signature of Patient or Personal Representative Date

_____

Relationship of Personal Representative to the Patient

BEAR CREEK COUNSELING CENTER

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.

This Notice is effective as of April 14. 2003.
We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

We are required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room (IF APPLICABLE: and on our web site). You may request a copy of the revised Notice at any time.
We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer also will take your complaints and can give you information about how to file a complaint. Our Privacy Officer is **Steve Hartman. M.A.. LPC** You can contact the Privacy Officer at *281/858-* 5874. **Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care operations.**

We may use information in your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if we want an opinion about your condition from a specialist, we may disclose information to the specialist to obtain that consultation.

We may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may use or disclose information from your record to allow "health care operations". These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

YOUR RIGHTS
You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions. You have a right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us.

You have a right to inspect the information in your record, and may obtain a copy of it. **This may be subject to certain limitations and fees.** Your request must be in writing. If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. **Your request must be in writing.**

You have the right to request an accounting of certain disclosures made by us. You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your health information).

You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints. Except as described in this Notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation.

In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization Use or disclosure of your protected health information that we are required to make without your permission. In certain circumstances, we are required by law to make a disclosure of your health information. For example, state law requires us to report suspected child abuse or neglect. Also, we must disclose information to the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information. Use or disclosure of your protected health information that we are allowed to make without your permission. There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

If you receive mental health care, including treatment for substance abuse, information related to that care may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others. We may use or disclose information from your record if we believe it is necessary to prevent or lessen a serious and imminent threat to the safety of a person or the public.
We may report suspected cases of abuse, neglect, or domestic violence involving adult or disabled victims.
We may report births and deaths to public health authorities, as well as certain types of diseases, injuries, adverse drug reactions, and product defects.
We may disclose information from your record to a medical examiner or coroner.
We may disclose information to funeral directors to allow them to carry out their duties upon your death.
We may disclose information from your record to facilitate organ, eye, or tissue donation and transplantation.

We may assist in health oversight activities, such as investigations of possible health care fraud. We may disclose information from your record as authorized by workers' compensation laws.

We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even if this is not ordered by a court.
We may disclose information from your record to a law enforcement official if certain criteria are met. For example, if such information would help locate or identify a missing person, we are allowed to disclose it.
If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, we may not disclose the information to law enforcement officials.
We may use or disclose information from your record for research under certain conditions. Under certain conditions, we may disclose information for specialized government purposes, such as the military, national security and intelligence, or protection of the President.

IF APPLICABLE: Your provider (or office staff) may contact you to provide appointment reminders as a courtesy. However, you are responsible for remembering your appointment.

IF APPLICABLE: We may contact you with information about treatment alternatives or other health- related benefits or services that may be of interest to you. NOTICE OF PRIVACY PRACTICES PERTAINING TO SUBSTANCE ABUSE RECORDS

The confidentiality of protected health information related to alcohol and drug abuse is protected by federal law and regulations. Violations of the applicable federal law and regulations is a crime, and may be reported to appropriate authorities.

We may not disclose any information about you unless you authorize the disclosure in writing, except as specified below.

We may disclose information about you if a court orders the disclosure.

We may disclose information about you in a medical emergency, to permit you to receive needed treatment.

We may disclose information about you for purposes of program evaluation, audits, or research.

We may disclose information about you if you commit a crime on our premises or against any person who works for us, or if you threaten to commit such a crime.

We are required to disclose information about you if we suspect child abuse or neglect. Except as stated in this notice, you have the same rights and protections with respect to your health information as described in our general Notice of Privacy Practices.