CounselingWorks®
Individual, couples and family therapy

Client Information Questionnaire – Adult

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please ask your counselor for clarification if you do not understand an item.

Full Name: _____ **Date:** _____

Address: _____

_____

Email Address: _____

Telephone Number(s): Cell: _____ Work: _____

Alternative Number(s) if applicable: _____

Please indicate if a message can be left at any of these numbers: _____

How did you hear about us? Please check one:

_____ Internet _____Family/Friend (name): _____

_____ Physician (name): _____ _____ Radio (name): _____

_____ Church (name): _____ ____School (name): _____

_____ Other: _____

Date of Birth: _____ **Gender (circle one):** Male Female

Ethnicity (circle one) *Optional: White Black Hispanic Asian Native American

Other: _____

Marital Status (circle one): Single Married Separated Divorced Remarried

Widowed Never Married

If never married, please skip this section:

1st marriage: Date began: _____ Date ended: _____ Name of spouse: _____

Children and ages: _____

2nd marriage: Date began: _____ Date ended: _____ Name of spouse: _____

Children and ages: _____

3rd marriage: Date began: _____ Date ended: _____ Name of spouse: _____

Children and ages: _____

Occupation: _____

Circle your highest level of education completed:

Grade school Middle school High school GED Some college Associate's degree

Bachelor's degree Master's degree Advanced degree (Ph.D., M.D., etc.)

Religious preference/affiliation: _____

Do you attend church? _____ **If so, where?** _____

Please list all other individuals that are currently living in your home and their relationship to you:

Name(s)	Age	Relationship	Ethnicity/Race

Have you adopted any children? _____ **If yes, give the name(s) of the adoptee(s) and the date(s) of adoption:**

_____

Were you adopted? _____ **If yes, at what age were you adopted and when?** _____

Have your parental rights ever been relinquished? _____ **If yes, when?** _____

Have you ever terminated a pregnancy? _____ **If yes, when?** _____

Who has custody of the minor children living in your home? _____

Would you like to sign a release of information (ROI) for anyone else to have rights to schedule your appointments, have access to information, or attend appointments with you? If yes, please indicate who below and ask your therapist for an ROI form to fill out.

_____

Briefly describe you main reason(s) for seeking counseling: _____

_____

_____

_____

_____

Briefly describe goals you would like to see achieved through therapy: _____

_____

_____

Have you ever seen a professional counselor before? (Circle one) Yes No

If yes, please provide the name or agency: _____

Did you find the counseling helpful? (Circle one) Yes No

If yes, how so? _____

_____

Are you currently taking any medications? (Circle one) Yes No

If yes, please list: _____

_____

Does the counselor have permission to contact your physician to coordinate services? (Circle one) Yes No

If yes, what is the physician/psychiatrist's name and number? _____

List any health problems with which you are struggling or have struggled in the past (i.e. diabetes, heart disease, obesity, cancer, etc.) _____

_____

Have you experienced the loss of someone close to you? If yes, please list below.

Name	Relationship to you	Date of death	Cause

Have you ever considered suicide? (Circle one) Yes No If yes, when? _____

Have you ever attempted suicide? (Circle one) Yes No If yes, when and how? _____

Circle any of the following items which are presently causing you difficulty:

Abuse	Decision making	In-laws	School	My past
Alcohol use	Depression	Level of energy	Self-concept/identity	My thoughts
Anger	Divorce	Legal matters	Self-control	Isolation
Ambition	Drug use	Loneliness	Self-harm/cutting	
Anxiety	Education	Marriage	Separation	
Appetite	Fears	Memory	Sexual problems	
Assertiveness	Finances	Nervousness	Shyness	
Auditory hallucinations	Friends	Nightmares	Sleep	
Confusion	Guilt	Parenting	Stress	
Career choices	Hopelessness	Premarital	Suicidal ideation	
Children	Health problems	Relaxation	Unhappiness	
Concentration	Inferiority	Religion/spirituality	Visual hallucinations	
Dating	Infidelity	Sadness	Work	

Please list the top three items that you would like to see addressed in therapy: _____

_____

Please list any additional changes you have noticed in yourself: _____

_____

Indicate any mental health issues(s) that exist in your <u>immediate or extended family</u>.
Name: Relationship to you: Diagnosis/mental health issue:

_____

_____

_____

Have you ever been physically, sexually, emotionally abused by an adult or person at least 5 years old than you?
Name of perpetrator: Relationship to you: Type of abuse: Date of abuse:

_____

_____

_____

_____

While you were growing up, during your first 18 years of life:

1. **Did a parent or other adult in the household often swear at you, insult you, put you down or humiliate you? Act in a way that made you afraid you might be physically hurt?** _____ Yes _____ No

   If yes, please describe: _____

   _____

   _____

   _____

2. **Did a parent or other adult in the household often push, grab, slap, or throw something at you? Ever hit you so hard that you had marks or were injured?** _____ Yes _____ No

   If yes, please describe: _____

   _____

   _____

   _____

3. **Did you often feel that no one in your family loved you or thought you were important or special? Your family didn't look out for each other, feel close to each other or support each other?** _____ Yes _____ No

   If yes, please describe: _____

   _____

   _____

   _____

4. **Did you often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Your parents were too drunk or high to take care of your or to take you to the doctor if you needed it?** _____ Yes _____ No

   If yes, please describe: _____

   _____

   _____

   _____

5. **Were your parents ever separated or divorced?** _____ Yes _____ No

   If yes, please describe: _____

   _____

   _____

   _____

6. **Was your mother or stepmother often pushed, grabbed, slapped, or had something thrown at her? Sometimes or often kicked, bitten, hit with a fist or hit with something hard? Ever repeatedly hit over at least a few minutes or threatened with a knife or gun?** _____ Yes _____ No

If yes, please describe: _____

_____

_____

_____

7. **Did you live with anyone who was a problem drinker or alcoholic or used illegal drugs?** _____ Yes _____ No

If yes, please describe: _____

_____

_____

_____

8. **Did a household member go to prison?** _____ Yes _____ No

If yes, please describe: _____

_____

_____

_____

Did you experience any childhood or adult trauma (not listed above) that has strongly impacted your life (divorce of a parent, loss of a close relative, abandonment by a parent, etc.)? _____ Yes _____ No

If yes, please describe: _____

_____

_____

_____

Please provide any additional information which you feel may be useful to your therapy at CounselingWorks.

_____

_____

_____

_____

_____

5440 Harvest Hill Road, Suite 140, Dallas, Texas 75230
(972)960-9981

CONSENT TO TREATMENT

CounselingWorks provides therapy and assessments which utilize systems, methods, and processes which include interpersonal, cognitive, cognitive-behavioral, developmental, psychodynamic, affective, family systems, and/or play therapy methods and strategies with individuals, couples and/or their families to achieve mental, emotional, physical, moral, educational, spiritual adjustment and/or career development through the changing individual and family life cycle. These approaches assist in stabilizing and alleviating mental, emotional or behavioral problems/issues of an individual, couple, or family. When an individual, couple or family makes changes, there is the possibility of discomfort or discord. If this occurs, the client(s) are asked to discuss this with the therapist. It is the hope of CounselingWorks to strengthen individuals and their families through Christian counsel.

I have read and understand the treatment as described above. I authorize CounselingWorks to provide for my care. I also understand that I may withdraw this consent and terminate treatment at any time.

_____	_____
Client	Witness
_____	_____
Client	Therapist
_____	_____
Client	Date

I,_____, have read the CounselingWorks Policies and Guidelines. By signing below, I acknowledge that I understand and fully accept the tenets of the policies and guidelines and my rights and responsibilities in entering a counseling relationship.

_____ _____

Client Signature Date

CounselingWorks

Individual, couples and family therapy

Consent to Receive Survey

One of the ways that we can better improve our services here at CounselingWorks is by hearing your feedback.

By signing this form you agree to receive an email from our offices with a survey upon the completion of your counseling. This survey can be completed at your own discretion, is anonymous, voluntary, and will not impact any services that you may receive from ChristianWorks in the future.

_____

Name of Client (Printed)

_____/____/_____

Signature Date

ChristianWorks for Children

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF HIPAA DEFINED PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I,_____, hereby state that by signing this Consent, I acknowledge and agree as follows:

The Provider's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Provider to provide treatment to me, and also necessary for the Provider to obtain payment for that treatment and to carry out its health care operations. The Provider explained to me that the Privacy Notice will be available to me in the future at my request. The Provider has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Provider reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that may be used by the Provider:
____Yes _____No — a letter mailed to me at the address provided by me
____Yes _____No — telephoning my home and leaving a message on my answering machine or with the individual answering the phone
____Yes _____No — telephoning my office and leaving a message on my phone mail or with the individual answering the phone
____Yes _____No — an email may be sent to an email address provided by me
____Yes _____No — a text may be sent to a number provided by me

The Provider may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Provider to treat me and obtain payment for that treatment, and as necessary for the Provider to conduct its specific health care operations.

I understand that I have a right to request that the Provider restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Provider is not required to agree to any restrictions that I have requested. If the Provider agrees to a requested restriction, then the restriction is binding on the Provider.

I understand that this Consent is valid for seven years and that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Provider has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Provider has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Provider will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Client (Printed) Signature of Client/Parent/Guardian

_____ _____
Signature of Legal Representative (e.g., Attorney-In-Fact) Relationship to Client

_____/_____/_____ _____
Date Signed Counselor

CounselingWorks®

Individual, couples and family therapy

A ministry of ChristianWorks for Children

COUNSELING POLICIES & GUIDELINES

Counseling**Works**, a service of Christian**Works** for Children, provides counseling and therapy for individuals, couples and families based on a Christian perspective of life with the Bible as the ultimate authority. The goal of services provided at Counseling**Works** is to help client's find fulfillment and a more abundant life through God and His Son Jesus Christ by seeking God's Will for their lives.

CREDENTIALS

- Our counselors acknowledge Jesus Christ as the pre-eminent model for Christian counseling.
- Our counselors are professing Christians, active in church attendance and ministry. They are willing to support the Christian mission and purpose.
- All of our counselors and staff agree to a Statement of Belief listing core beliefs that identify them as professing and practicing Christians. (A copy of the Statement of Belief is attached to this document.)
- Our counselors are licensed by the State of Texas, have a temporary license while working towards a permanent license, or are counselor interns under the supervision of a fully licensed counselor.
- Our counselors have academic degrees from accredited colleges and universities in counseling or social work.
- Our counselors continue to update their professional knowledge and skills on the latest counseling and therapy research, theory and techniques.

CONFIDENTIALITY

Clients of Counseling**Works** are required to sign a consent required by all healthcare providers which is compliant with HIPAA concerning their privacy rights.

Counseling**Works** counselors have an ethical and moral obligation to keep information revealed in counseling sessions confidential. The counselors work as a treatment team and can at times consult with one another in an effort to develop the best possible treatment plan for the client. Although your case may be discussed with additional counselor(s), please be assured that your anonymity and confidentiality will be preserved.

All information in counseling sessions is a private matter between the client and the counselor so far as allowed by the laws of the State of Texas. Under certain conditions, the right to confidentiality is necessarily violated:

1. If any individual or member of the family expresses intent to physically harm themselves, it will be reported to appropriate family members, medical officials, and local law enforcement or, with the client's written permission, a friend or relative.
2. If any individual or member of the family expresses intent to physically harm someone else, it will be reported to local law enforcement officials.
3. If any individual or member of the family mentions any child neglect or abuse, elder neglect or abuse, or neglect or abuse to the disabled, by law, it must be reported to the appropriate official authorities.
4. If any individual or member of the family mentions any abuse or sexual exploitation by a mental health provider, according to state board ethical and professional requirements, it must be reported to the appropriate official authorities.
5. If an adult individual or member of the family gives written authorization to the counselor for the release of information to specified person, that information may be released.
6. If a counselor is ordered by a court of law to release records or information concerning counseling session(s), the information must be shared.

CONSENT TO TREATMENT

Clients are required to sign a consent for treatment form acknowledging the benefits and risk of counseling and therapy. Persons in counseling frequently make significant changes in their lives. The client may withdraw consent and terminate treatment at any time.

CLIENT FEE(S)

To serve the needs of the community and to make quality counseling and therapy more readily available to clients, the counseling fees at Counseling**Works** based on an ability to pay and are lower than most counseling agencies. Counseling fees are charged on a sliding scale fee based upon the gross individual or family income.

- Documentation to evidence the individual or family income will be required.
- Payment of the counseling fee is required at the end of each 50 minute session. Payment can be made in cash, by check, or with approved credit cards (Visa, MasterCard, Discover and American Express).
- All checks must be made payable to ChristianWorks for Children.

- Clients will be billed for one half (50%) of the counseling fee for all missed weekday appointments, unless the session is cancelled by the client 24 hours in advance of the appointment.

- Clients will be billed for the full counseling fee (100%) for all missed weekend appointments, unless the session is cancelled by the client 24 hours in advance of the appointment.

- Payments must be current in order to schedule another counseling appointment.

- Fees for other counseling or therapy related services (such as support groups) will vary with the service provided. Clients will be notified of the fees and when payment is to be made in advance of the services provided.

- Co-payment fees for Church Sponsorship clients will be $20 per session except:

    1. When the client has exceeded the number of sessions per client allowed in the specific Church Sponsorship contract. Once that church sponsorship limit has been reached, all sessions after that will be at the standard CounselingWorks sliding fee scale. If the client wishes to have the limit extended, it will be the responsibility of the client to contact church leadership contacts to ask for that extension.
    2. When the client is no longer a member of the church contracted with the Church Sponsorship Program. It is the responsibility of the client to notify the counselor or a CounselingWorks staff member when they discontinue their membership at the participating sponsor church. When the client has discontinued membership with the sponsoring church, client fees will be set at the standard CounselingWorks sliding scale fee.

SPECIAL FEES:

For court or legal activities:

- Fees for court appearances by any of the CounselingWorks counselors or staff will be assessed at $95 per hour (one hour minimum will be charged). This includes the counselor's court preparation and transportation time to and from the appearance in court, legal hearing and/or activity. A statement of charges will be sent to the person(s) requesting the counselor's time and appearance.
- Fees will be charged for the preparation of requested counseling records and documents appropriate to cover the costs of photocopying, emailing, faxing and office staff time involved. A statement of charges will be sent to the person(s) requesting the counseling records and documents.

CLIENT RESPONSIBILITIES AND SCHEDULING

In order for you to benefit the most from your sessions, it is important that you cooperate with the follow requests throughout the time you are involved with Counseling**Works**.

- Please cancel a session only when it absolutely necessary. When you must cancel, please notify the Counseling**Works** staff within 24 hours of the appointment. In emergency situations where calling 24 hours in advance is not possible, please call as soon as you can. The staff will work with you to see your needs are met and another appointment may be set.
- You will be billed one half (50%) of the counseling fee for missing any weekday (Monday-Friday) appointment or canceling less than 24 hours in advance.
- You will be billed the full fee (100%) for missing any weekend (Saturday) appointment or canceling less than 24 hours in advance.
- Please show up for an appointment on time. Sessions are 50 minutes in length. If you show up late, the session will not be extended to compensate for being late.
- If a client's counselor is 10-15 minutes late or later in starting a session, the client can cancel the current session at that time without financial penalty and reschedule for a time that will be convenient for both client and counselor. The client must report the decision to cancel and reschedule the current session to his/her counselor or another CounselingWorks staff member.
- Please bring a means of payment for the session. The fee is due when services are rendered. You may pay by cash, check or an approved credit card. **Further appointments cannot be set until payments are up to date.**
- If you "no show" for an appointment, it is your responsibility to call and schedule another appointment. Another appointment time will not be automatically held for you.
- If you "no show" for two consecutive appointments, it is possible that no further appointments may be made.
- Please keep the waiting area quiet and orderly for all Counseling**Works** clients. Make sure you and your family members place magazines, books, games and toys back from where you got them.
- Understand that counseling is a collaborative effort between you and the counselor. If you are actively invested and participating in the counseling process, issues can be resolved more quickly and efficiently.
- If a client wishes to report specific concerns or grievances about the counseling services being provided them, he/she should first address the issue with the counselor. If after doing so the client is still dissatisfied, he/she may report the issue to the CounselingWorks Director at 972-960-9981.

OFFICE HOURS

The office is open Monday-Friday with normal business staff hours of 9:00 a.m.-5:00 p.m. **Calls after 5:00 p.m. are answered by an automated system**. Counseling appointments can be set normally during the following hours:

Monday: 9:00 a.m. – 8:00 p.m.
Tuesday: 9:00 a.m. – 8:00 p.m.
Wednesday: 9:00 a.m. – 8:00 p.m.
Thursday: 9:00 a.m. – 8:00 p.m.
Friday: 9:00 a.m. – 8:00 p.m.
Saturday 9:00 a.m. – 3:00 p.m.

The doors to the building automatically lock at 8 p.m. Monday through Friday and at 3 p.m. Saturdays. If your counselor is not at the door to let you in for your appointment, please call 972-960- 9981 and leave a message on extension 106. The doors locking is totally under the control of the office complex security system.

AFTER HOURS CONTACT

Non-emergency messages can be left on voice mail for counselors or staff members by calling the office phone number 972-960-9981. If an emergency situation exists, you can call 9-1-1 for help. Other numbers of importance for after hours:

National Suicide Prevention Lifeline 800-273-TALK (800-273-8255) Suicide Crisis Line: 214-828-1000 www.sccenter.org
Child Protective Services: 1-800-252-5400 https://www.dfps.state.tx.us/child_protection

Substance Abuse Helpline:	214-522-8600	800-246-4673 dallascouncil.org
12 Step/ AA Meetings:	214-887-6699	www.aadallas.org
Dallas Al-Anon:	214-363-0461	dallasal-anon.org

Celebrate Recovery: http://grouplocator.crgroups.info/

THIS IS A COPY OF THE STATEMENT OF FAITH SIGNED AND ADHERED TO BY ALL CHRISTIANWORKS COUNSELORS AND STAFF.

ChristianWorks for Children®
Building healthy families since 1967

Adoption**Works** Counseling**Works** Grief**Works** Kid**Works** Care**Works** Statement of Faith

The Board recognizes that Christian Works for Children is not the church. We are a Christian ministry founded by the Churches of Christ. Because we seek to serve our church constituents effectively, to be united in our service to Jesus Christ as He has modeled for us, and to be guided by the teachings of Jesus Christ as revealed in the Bible, we expect all full time staff, all board members, all counselors, all volunteers engaged in facilitating children's support groups, and all adoptive and foster parents to fully embrace and commit to this statement of faith and beliefs.

Accordingly we believe:

1. The Bible is the inspired word of God, the supreme and final authority in faith and conduct, which reveals the nature of God, Jesus Christ, and the Holy Spirit (2 Tim. 3:16; 1 Pet. 1:19- 21).
2. God interacts with this world as Creator and Savior through Jesus Christ (Gen. 1; Heb. 1:1-3; John 1:1-5; 12-13).
3. God is honored when we imitate the nature of God and his son through the guidance of the Holy Spirit (John 3:13-17; 1 Cor. 11:1; 2 Pet. 2:21).
4. Jesus Christ is the son of God. He was conceived by the Holy Spirit and born in the flesh to a virgin. He was crucified with the foreknowledge of God as atonement for man's sin, was raised from the dead, and has ascended to the right hand of God. Through Him only we have access to God (John 3:13-17; John 14:6; Acts 2:22-23; 1 Cor. 15:1-4).
5. Salvation of man is only through God's gift of grace for those who put their faith only in Jesus Christ for their justification. Faith is demonstrated by obeying His command to be baptized in water reflecting the death, burial, and resurrection of Jesus (Eph. 2:8-9, Gal. 2:16, Gal. 3:26-27, Rom. 6:3-4, 23, Acts 2:37-39, Matt. 28:18-20).
6. Those who have accepted God's gift of grace and demonstrated their faith have fellowship with Him if we walk in the light as He in the light, and the blood of Jesus His Son cleanses us from all sin (1 John 1:5-10)

7. Jesus Christ established His church and placed himself as head (Eph. 1:22-23, 5:23; Matt. 16:18).

8. God interacts with believers through the Holy Spirit as Helper, Teacher, Guide, and convicts all mankind of sin, righteousness, and judgment (John 14:26, 15:26, 16:13; Acts 9:31).
9. God is to be worshipped in spirit and truth. God calls us to participate regularly in worship and service, to praise him and mutually encourage and build each other up in Jesus Christ (John 4:24; Acts 2:42-47; Heb. 10:23-25).
10. Like Jesus, children should grow in the knowledge and wisdom of God as they age, increasing in favor with God and man (Luke 2:40, 52; Matt. 19:13-14).
11. Jesus Christ is glorified by our conduct and effort to do our best in everything we do, knowing it is Him we serve (Col. 3:12-14, 17, 23-24).
12. Every person must be afforded compassion, love, kindness, respect, and dignity (Mark 12:28-31; Luke 6:31.) Hateful and harassing behavior or attitudes directed toward any individual are to be repudiated and are not in accord with Scripture.
13. God has established marriage as a lifelong, exclusive relationship between one man and one woman and which is intended to last a lifetime (Gen. 2:24-25; Ex. 20:14, 17, 22:19; Lev. 18:22-23, 20:13, 15-16; Matt. 19:4-6, 9; Rom. 1:18-31; I Cor. 6:9-10, 15-20; I Tim. 1:8-11; Jude 7; Gen. 1:27; Deut. 22:5).
14. All human life is sacred and created by God in His image. Human life is of inestimable worth in all its dimensions, including pre-born babies, the aged, the physically or mentally challenged, and every other stage or condition from conception through natural death. We are therefore called to defend, protect, and value all human life (Ps 139).

HIPAA NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY

This Provider is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Provider. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

CONSENT

The Provider may use and/or disclose your PHI provided that it first obtains a valid Consent signed by you. The Consent will allow the Provider to use and/or disclose your PHI for the purposes of:

3. Treatment – In order to provide you with the health care you require, the Provider will provide your PHI to those health care professionals, whether on the Provider's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you may need to know the condition for which you are being counseled by this office.
4. Payment – In order to get paid for services provided to you, the Provider will provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements. For example, the Provider may need to provide information to your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.
5. Health Care Operations – In order for the Provider to operate in accordance with applicable law and insurance requirements and in order for the Provider to continue to provide quality and efficient care, it may be necessary for the Provider to compile, use and/or disclose your PHI. For example, the Provider may use your PHI in order to evaluate the performance of the Provider's personnel in providing care to you.

NO CONSENT REQUIRED

The Provider may use and/or disclose your PHI, without a written Consent from you, in the following instances:

a. De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.
b. Business Associate – To a business associate if the Provider obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Provider in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payors.

c. Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

d. Emergency Situations –

(i) for the purpose of obtaining or rendering emergency treatment to you provided that the Provider attempts to obtain your Consent as soon as possible; or

(ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

e. Communication Barriers – If, due to substantial communication barriers or inability to communicate, the Provider has been unable to obtain your Consent and the Provider determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

f. Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.

g. Abuse, Neglect or Domestic Violence - To a government authority if the Provider is required by law to make such disclosure. For example, the Provider is required by Section 681.43 of the Texas Administrative Code to report (1) abuse or neglect of minors, (2) abuse, neglect, or exploitation of elderly or disabled persons, (3) abuse, neglect, and illegal, unprofessional, or unethical conduct in an inpatient mental health facility, a chemical dependency treatment facility, or a hospital providing comprehensive medical rehabilitation services, and (4) sexual exploitation by a mental health services provider.

h. Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

i. Judicial and Administrative Proceeding - If you are involved in a lawsuit or a dispute, the Provider may disclose medical information about you in response to a subpoena, a court order, or administrative order. For example, the Provider may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

j. Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena, court order, warrant, summons or similar process. The Provider may disclose your PHI if the Provider believes that a death was the result of criminal conduct. The Provider may disclose your PHI to law enforcement officials to identify or locate a suspect, fugitive, material witness, missing person, or to report a crime.

k. Coroner or Medical Examiner - The Provider may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

l. Organ, Eye or Tissue Donation - If you are an organ donor, the Provider may disclose your PHI to the entity to whom you have agreed to donate your organs.

m. Research - If the Provider is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.

n. Avert a Threat to Health or Safety - The Provider may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

o. Specialized Government Functions - This refers to disclosures of PHI that relate primarily to military and veteran activity.

p. Workers' Compensation - If you are involved in a Workers' Compensation claim, the Provider may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

q. National Security and Intelligence Activities – The Provider may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.

r. Military and Veterans – If you are a member of the armed forces, the Provider may disclose your PHI as required by the military command authorities.

s. Protective Services for the President and Others - The Provider may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special investigations.

APPOINTMENT REMINDER

The Provider may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders may be used by the Provider: (a) a postcard mailed to you at the address provided by you; (b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone; and/or telephoning your office and leaving a message on your phone mail or with the individual answering the phone.

DIRECTORY/SIGN-IN LOG AND APPOINTMENT CALENDAR

The Provider does not maintain a sign-in log for individuals seeking care and treatment in the Provider's office. The Provider does maintain an appointment calendar which is located in a position where the Provider and staff can readily see who is seeking care in the office. This information may be seen by others who are seeking care or services in the Provider's office.

FAMILY/FRIENDS

The Provider may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Provider may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

a. If you are present at or prior to the use or disclosure of your PHI, the Provider may use or disclose your PHI if you agree, or if the Provider can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

b. If you are not present, the Provider will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to:

a. Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Provider's Privacy Officer.

b. Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Provider is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Provider's Privacy Officer. In your written request, you must inform the Provider of what information you want to limit, whether you want to limit the Provider's use or disclosure, or both, and to whom you want the limits to apply. If the Provider agrees to your request, the Provider will comply with your request unless the information is needed in order to provide you with emergency treatment.

c. Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Provider's Privacy Officer. The Provider will accommodate all reasonable requests.

d. Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Provider's Privacy Officer. The Provider can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Provider may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

e. Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Provider's Privacy Officer. You must provide a reason that supports your request. The Provider may deny your request (1) if it is not in writing, (2) if you do not provide a reason in support of your request, (3) if the information to be amended was not created by the Provider (unless the individual or entity that created the information is no longer available), (4) if the information is not part of your PHI maintained by the Provider, (5) if the information is not part of the information you would be permitted to inspect and copy, and/or (6) if the information is accurate and complete. If you disagree with the Provider's denial, you will have the right to submit a written statement of disagreement.

f. Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Provider's Privacy Officer. The request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Provider may charge you for the cost of providing additional lists. The Provider will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

g. Receive a paper copy of this Privacy Notice from the Provider upon request to the Provider's Privacy Officer.

h. Complain to the Provider or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Provider, you must contact the Provider's Privacy Officer. All complaints must be in writing.

i. To obtain more information on, or have your questions about your rights answered, you may contact the Provider's Privacy Officer, Larry M. Barber, at ChristianWorks for Children, 5440 Harvest Hill Road, Suite 140, Dallas, Texas 75230, phone number 972-960-9981.

PROVIDER'S REQUIREMENTS

The Provider:

a. Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Provider's legal duties and privacy practices with respect to your PHI.
b. Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your mental health records than is provided for under federal law. In particular, the Provider is required to comply with the Texas Health and Safety Code, Chapter 611, concerning confidentiality and access to records.
c. Is required to abide by the terms of this Privacy Notice.
d. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
e. Will distribute any revised Privacy Notice to you prior to implementation.
f. Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of April 14, 2003 and updated as of 10/13/04.