Anne M. Causey, M.A., LPC
Client Information Form

Date _____

Client Name _____ Gender M F Birthdate_____

Marital Status: ___Married ___Divorced ___Single

Address_____ City _____ State___ Zip_____

School or Employer _____

Cell Phone_____ Home Phone_____ Work Phone_____

Responsible Party Information

Name _____ Gender M F Birthdate_____

Address_____ City _____ State___ Zip_____

School or Employer _____ Relationship to Client_____

Cell Phone_____ Home Phone_____ Work Phone_____

Consent to Treatment

I _____, hereby give my consent for treatment by Anne M. Causey, M.A., LPC. I also understand and agree that I am responsible for fees incurred for services rendered by Anne M. Causey, M.A., LPC at the time those services are rendered, and that I may also incur fees if I fail to cancel my appointment within 24 hours or fail to show up for a scheduled appointment.

Consent to Treat Minor

I _____, hereby attest that I am the legal guardian of _____ and I have the legal right to give my consent for his/her treatment by Anne M. Causey, M.A., LPC. I also understand and agree that I am responsible for fees incurred for services rendered to _____by Anne M. Causey, M.A., LPC at the time those services are rendered, and that I may also incur fees if I fail to cancel a scheduled appointment within 24 hours or fail to show up for a scheduled appointment.

Anne M. Causey, M.A., LPC
White Stone Associates
26205 Oakridge Drive, Ste. 8
The Woodlands, TX 77380
Office number: (832) 492-5068
Fax number: (281) 292-2365

Client Information

Counseling Relationship: Thank you for choosing White Stone Associates. I am privileged to have the opportunity to serve you. The counseling relationship is designed to be one that will facilitate change. Both the counselor and the client have active roles. My role will be to create an environment of trust and warmth, and to give direction. Your role will be to identify the goals that you would like to have as the focus of your therapy and to examine areas of your life that presently prevent you from meeting your goals. Due to the nature of the therapeutic relationship, it is considered unethical for me to acknowledge or approach you in any setting outside of this office. It is appropriate and permissible for you to approach me, but as your therapist I do not hold this same privilege with you.

Qualifications: I have a master's degree in Counseling from Northeastern Illinois University. I am licensed to practice counseling in the state of Texas. My license is issued by the Texas State Board of Examiners of Professional Counselors. This board can be reached by writing 1100 West 49th Street, Austin, TX 78756 or by calling (512) 834-6658.

Areas of Expertise: My practice includes adults, couples, adolescents and children. I am available for individual, marital, family and group counseling. I have over twenty-five years of experience serving as a counselor. Eight of those years were spent in a church setting. Following that, I have been in private practice for 17 years.

Fee Structure: The session fee for an initial assessment is $150 and is 50 to 60 minutes in length. Thereafter, regular sessions are 45-50 minutes in length with a fee of $120. We require a credit card to be place on file at the time you schedule your appointment to hold your appointment time

Cancellations: Because of the nature of my practice I have a limited number of appointments available. Therefore, I must request 24 hours advance notice of cancellation of your scheduled appointment time so that I may try to fill your vacancy. . **Sessions that are cancelled within less than 24 hours prior to the scheduled session time and appointments that are not cancelled and not attended will be charged at the full rate, including initial assessments**. If you cannot reach me directly, you may leave a message for me at (832) 492-5068.

Code of Conduct: My services are provided in accordance with the Code of Conduct for Licensed Professional Counselors as set forth by the LPC Licensing Board. A copy of this Code is available upon request. If you have any questions or concerns at any time, please feel free to discuss them with me. If I am unable to resolve the matter to your satisfaction, I may request that you get a consultation with another therapist.

Potential Risks of Counseling: In the course of counseling it is possible that additional issues other than those you originally presented, may surface. The awareness of these added issues may be experienced as stressful or painful.

Privileged Communication and Confidentiality: Information revealed by you during counseling will be kept confidential and will not be revealed to any person or agency without your permission, except as described below:

(4) In the event you become unable to care for yourself or there is good reason to suspect suicidal behavior, I am able to waive the right of confidentiality in order to ensure your safety.

(4) If you threaten bodily harm or death to another person, I may be required to inform the intended victim and the appropriate law enforcement agencies.

(5) If you report to me your knowledge of the continuing physical or sexual abuse of a minor by an adult, I am required by law to inform Child Protective Services, which may decide to investigate the matter.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), **neither you nor your attorneys, nor anyone else acting on your behalf will call Anne Causey to testify in court** or any other proceeding, nor will disclosure of the psychotherapy records be requested. If I am subpoenaed to court, you agree that my reimbursement rate will be $360 per hour, including travel time.

Emergency Situations: If you experience a life threatening emergency, please call 911 or go to the nearest hospital emergency room immediately. If a situation is urgent, you may call me at (832) 492-5068. If I am not available, please leave a message for me and I will return your call as soon as possible. I usually am able to return calls within one business day.

Client Responsibilities: The professional Code of Conduct stipulates that if you, the client, begin a new relationship with another mental health provider, permission must be granted by the first therapist for a second therapist to work with the same client. Please inform me of any other ongoing professional mental health relationship.

Prayer: As a Christian, I would welcome the opportunity to pray with you at the beginning or end of our sessions. Please let me know if this is something you desire.

The signature(s) below confirm that the above information has been read and discussed with Anne Causey, and that I, the undersigned, accept the policies listed above.

_____

Client's Name (printed)

_____ _____

Client's Signature (or guardien if client is a minor) Date

Anne M. Causey, M.A., LPC
White Stone Associates
26205 Oak Ridge Drive
The Woodlands, TX 77380
Office number: (832) 492-5068
Fax number: (281) 292-2365

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this notice indicate that you have been given the opportunity to review and request a copy of Anne M. Causey M.A., LPC's Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information Anne M. Causey M.A., LPC's Notice of Privacy Practices, please do not hesitate to contact the office as indicated on your Notice. You may make a written request for a copy of the above referenced Notice of Privacy Practices at any time.

_____
Please print the client's name above

_____
Please print guardian's name above if client is a minor

_____
Client's Signature (or guardian if client is a minor)

Date Notice was Received: _____

Notice of Privacy Practices

How Your Medical Information May Be Used and Disclosed &
How You Can Access This Information

Understanding Mental Health Record Information

Each time you visit a hospital, a physician, or another health care provider, the provider makes a record of your visit. Typically this record contains your health history, current symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, serves as the following:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care that you received.
- Means by which you or a third-party payer can verify that you received the services billed for.
- Source of information for public health officials charged with improving the health of the regions they serve.
- Tool to assess the appropriateness and quality of care that you received.
- Tool to improve the quality of health care and achieve better patient outcomes.

Understanding what is in your health records and how your health information is used helps you to:

- Ensure its accuracy and completeness.
- Understand who, what, where, why, and how others may access your health information.
- Make informed decisions about authorizing disclosure to others.
- Better understand the health information rights detailed below.

Your Rights under the Federal Privacy Standard

Although your health records are the physical property of the health care provider who completed the records, you have the following rights with regard to the information contained therein:

- Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. This includes activities necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under the following: (i) disclosures to you, (ii) for facility directories, but note that you have the right to object to such uses, or (iii) uses and disclosures not requiring a consent or an authorization. The latter uses and disclosures include, for example, those required by law, such as mandatory communicable disease reporting. In those cases, you do not have a right to request restriction. The consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction, except in the situation explained below. If we do, we will adhere to it unless you request otherwise or we give you advance notice. You may request restriction or alternate communications on the consent form for treatment, payment, and health care operations. **If,** however, you request restriction on a disclosure to a health plan for purposes of payment or health care operations (not for treatment), we must grant the request if the health information pertains solely to an item or a service for which we have been paid in full.
- Obtain a copy of this notice of information practices upon request.
- Inspect and copy your health information upon request. In certain situations, such as if access would cause harm, we can deny access. You do not have a right of access to the following:
  - Psychotherapy notes. Such notes consist of those notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing a conversation during a private, group, joint, or family counseling session and that are separated from the rest of your medical record.
  - Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.

- Protected health information ("PHI") that is subject to the Clinical Laboratory Improvement Amendments of 1988, to the extent that giving you access would be prohibited by law.
- Information that was obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of the information.

In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying access. These "reviewable" grounds for denial include the following:

- A licensed health care professional has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of yourself or another person.
- PHI makes reference to another person (other than a health care provider) and a licensed health care provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.
- The request is made by your personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person.

For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable fee for making copies.

- Request amendment/correction of your health information. We do not have to grant the request if the following conditions exist:
  - We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record.
  - The records are not available to you as discussed immediately above.
  - The record is accurate and complete.

  If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.
- Obtain an accounting of nonroutine uses and disclosures, those other than for treatment, payment, and health care operations. We do not need to provide an accounting for the following disclosures:
  - To you for disclosures of protected health information to you.
  - For the facility directory or to persons involved in your care or for other notification purpose.
  - For national security or intelligence.
  - To correctional institutions or law enforcement officials.

  We must provide the accounting within 60 days. The accounting must include the following information:
  - Date of each disclosure.
  - Name and address of the organization or person who received the protected health information,
  - Brief description of the information disclosed.
  - Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization or a copy of the written request for disclosure.

  The first accounting in any 12-month period is free. We then reserve the right to charge a reasonable fee.
- Revoke your consent or authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.

Our Responsibilities under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to take the following measures:

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical,

administrative, and technical safeguards to protect the information.

- Provide you this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
- Abide by the terms of this notice.
- Train our personnel concerning privacy and confidentiality.
- Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies.
- Mitigate (lessen the harm of) any breach of privacy/confidentiality. We will not use or disclose your health information without your consent or authorization, except as described in this notice or as required by law.

How to Get More Information or to Report a Problem

If you have questions and/or would like additional information, you may contact the director of health information management.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION THAT WE MAINTAIN.

Examples of Disclosures for Treatment, Payment, and Health Care Operations

If you give us consent, we will use your health information for treatment.
Example: A physician or other member of your health care team will record information in your record to diagnose and treat your condition. The primary caregiver may give treatment orders and/or communicate with other members of the health care team for your treatment. We may also provide your physician, other health care professionals, or a subsequent health care provider, copies of your records to assist them once we are no longer treating you.

If you give us consent, we will use your health information for payment.
Example: We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, and treatment received.

If you give us consent, we will use your health information for health care operations.
Example: Members of the medical or administrative staff may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide.

Business associates: We provide some services through contracts with business associates. Examples include certain diagnostic tests, a copy service to make copies of medical records, and the like. When we use these services, we may disclose your health information to the business associates so that they can perform the function(s) that we have contracted with them to do and bill you or your third-party payer for services provided. To protect your health information, however, we require the business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, a personal representative, or another person responsible for your care, location, and general condition.

Communication with family: Unless you object, health professionals, using their best judgment, may disclose to a family member, another relative, a close personal friend, or any other person that you identify health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board.

Funeral directors: We may disclose health information to funeral directors to carry out their duties.

Marketing/ continuity of care: We may 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.

Food and Drug Administration ("FDA "): We may disclose to the FDA health information relative to adverse effects/events with respect to medications.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Health oversight agencies and public health authorities: If members of our work force or business associates believe in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public, they may disclose your health information to health oversight agencies and/or public health authorities such as the department of health.

- *The Federal Department of Health and Human Services ("DHHS"):* Under the privacy standards, we must disclose your health information to DHHS as necessary to determine our compliance with those standards.

Effective date: February 1, 2013

Anne M. Causey, M.A., LPC
Intake Questionnaire

Please answer the questions below to the best of your ability. The purpose of the questionnaire is to obtain a comprehensive picture of your background to facilitate your therapy process.
In couples therapy each partner should complete a separate questionnaire.

Client Name_____ Birthdate_____ Age _____

Address_____

City_____ State _____ Zip Code_____

Cell Phone_____ Home Phone_____ Work Phone_____

What made you decide to come today? _____
How long have you felt this way? _____
What are your symptoms? _____
What are your goals for your therapy?_____

Are you currently having suicidal thoughts? Yes No

Have you ever seen a therapist before? Yes No
When? _____
For how long? _____
Did it help? Yes No

Have you ever

Harmed yourself?	Yes	No	When/How _____
Attempted suicide?	Yes	No	When/How _____
Been hospitalized?	Yes	No	When/Why _____
Been arrested?	Yes	No	When/Why _____

Have you ever experienced trauma?

Mental abuse	Yes	No	When/Who _____
Verbal Abuse	Yes	No	When/Who _____
Physical Abuse	Yes	No	When/Who _____
Sexual Abuse	Yes	No	When/Who _____
Combat	Yes	No	When _____
Bullying	Yes	No	When/Who _____
Abandonment	Yes	No	When/Who _____
Divorce	Yes	No	When _____
Loss of job	Yes	No	When/How _____
Loss of family member	Yes	No	When/How _____

Parent When/How _____
Sibling When/How _____
Other When/How _____

Anne M. Causey, M.A., LPC
Intake Questionnaire

Client Name_____ Birthdate_____

Do you or any family members struggle with

Anxiety	Yes	No	When _____
Depression	Yes	No	When _____
OCD	Yes	No	When _____
Substance Abuse	Yes	No	When _____
Alcoholism	Yes	No	When _____
ADD	Yes	No	When _____
Mania	Yes	No	When _____

Please list current medications and dosages:

How would you describe your

Childhood	Very Bad	Poor	Average	Good	Very Good
Relationship with your mother	Very Bad	Poor	Average	Good	Very Good
Relationship with your father	Very Bad	Poor	Average	Good	Very Good
Relationship with siblings	Very Bad	Poor	Average	Good	Very Good
Relationship with peers	Very Bad	Poor	Average	Good	Very Good
Relationship with your spouse	Very Bad	Poor	Average	Good	Very Good
Relationship with your children	Very Bad	Poor	Average	Good	Very Good

During childhood did you experience

Premature at birth	Yes	No	
Physical issues	Yes	No	When/What _____
Surgeries	Yes	No	When/What _____
Developmental issues	Yes	No	When/What _____
Divorce of parents	Yes	No	What Age_____

What is your highest level of education? _____

What is your current occupation? _____

List your strengths_____

List your weaknesses_____

Thank you for completing your questionnaire! Please sign and date below:

_____ _____

Client's Signature (or parent if client is a minor) Date