

Tony Carroll, LCSW

Consultation, Counseling, Psychotherapy, Workshops
Adult Individuals and Couples
1006 Missouri Street, Houston, Texas 77006
Telephone: 713.527.0000 ♦ Fax: 713.529.4337
www.HoustonTherapist.com



This form compiles information helpful to Mr. Carroll. The Office Policies section fulfills the federal law requirements presented by the Health Information Portability and Accountability Act of 1996.
Mr. Carroll will only be able to speak with you after this form is completed and the "office policies" section has been read, signed, and initialed.

Contact information

| | | | | |
|------------------------------|------------------------|-------------------------------|---------------|-----|
| Name | | Date | | |
| Address | | City | State | Zip |
| Home Phone: | Work Phone | Mobile Phone | | |
| Email (Please print clearly) | | | Date of Birth | |
| Age | Social Security Number | Texas Driver's License Number | | |
| Business Name | | Occupation | | |
| Business Address(Street) | | City, St, Zip | | |

Relationship/Marriage History

| | | |
|---------------------------------|---------------------|-----|
| Present Spouse/Partner | Occupation | Age |
| Beginning Date of Relationships | Length of Courtship | |
| Describe your present situation | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Previous Marriages/relationships with names, dates, and reasons for termination:

| |
|-----|
| (1) |
| (2) |
| (3) |
| (4) |
| (5) |

Children/Step-Children

| Children and their ages | Step-children and their ages |
|-------------------------|------------------------------|
| | |
| | |
| | |
| | |
| | |

Financial Situation

| Self | Partner |
|-----------------------------|-----------------------------|
| Income | Income |
| Present financial situation | Present financial situation |
| | |

Educational Background

| Self | | | Partner | | |
|-------------|---------------|------------|-------------|---------------|------------|
| School | Location/Year | Completed? | School | Location/Year | Completed? |
| High School | | | High School | | |
| College | | | College | | |
| Graduate | | | Graduate | | |
| Post Grad | | | Post Grad | | |

Religious Background

| Self | Partner |
|------------------------------|------------------------------|
| Childhood religion | Childhood religion |
| Present affiliation | Present affiliation |
| Present Level of Involvement | Present Level of Involvement |
| | |

Family of Origin

| Mother | | Father | |
|---|--------------------|---------------------------------|--------------------|
| Name | | Name | |
| Present age | If deceased, year? | Present age | If deceased, year? |
| Health Condition | Occupation | Health Condition | Occupation |
| Education | | Education | |
| Present Relationship with you | | Present Relationship with you | |
| Childhood Relationship with you | | Childhood Relationship with you | |
| Divorced/remarried/when | | Divorced/remarried/when | |
| Describe their relationship as you understand it: | | | |

Siblings *(List by ages and include yourself)*

| Name | Age | Marital Status | Location | Occupation | Relationship between you |
|------|-----|----------------|----------|------------|--------------------------|
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Emergency Information *Who is best to contact should there be an emergency?*

| Name | Name |
|---------------|---------------|
| Relationship | Relationship |
| Day Phone | Day Phone |
| Evening Phone | Evening Phone |
| Mobil Phone | Mobile Phone |

Personal Health

| | |
|---|--------------------------|
| What, if any, physical problems do you currently have? | |
| | |
| List medications you use, their purpose, and the prescribing physician for each | |
| | |
| | |
| | |
| General Practice Physician | Phone Number or Location |

Consultation/Counseling/Psychotherapy History

| |
|---|
| What is your previous experience or knowledge of therapy? |
| |
| Give therapists, dates, and issues involved in previous therapies. |
| |
| What were those experiences like for you? |
| |
| |
| What is going on in your life which prompted your decision to begin therapy at this time? |
| |
| |
| |
| How did you know about Mr. Carroll? |
| Who suggested you come here at this time? |
| Describe the present situation as you understand it. |
| |
| |
| |
| Describe what you hope to gain from our work together. |
| |
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| |
| |
| If 10 is the best things have ever been for you, and 0 is the worst, where are you today? |

Depression/Anxiety/Substance Abuse Check List

Name _____

Date _____

| | | Yes | No | Maybe |
|-----|--|--------------------------|--------------------------|--------------------------|
| 1. | Blue or depressed mood characterized by such things as sadness, hopelessness, down in the dumps, irritability, helplessness? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | <u>Change in appetite, and or weight except when intentional?</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Loss of enjoyment from usual sources such as recreation, sex, social contacts, friends, hobbies? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | <u>Changes in sleep patterns?</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Slowing or acceleration of psychomotor activities? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <u>Loss of energy; fatigue?</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | Feelings of worthlessness, self-reproach, or excessive or inappropriate guilt? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <u>Reduced or impaired concentration?</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | Difficult with memory? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <u>Increased thoughts of death or dying?</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | Wishing to be dead? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. | <u>Thoughts of suicide?</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | If "yes" or "maybe" to number 12, please complete the following: | | | |
| A. | I have a plan for suicide | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. | I have a time in mind for carrying out that plan | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. | I have attempted suicide in the past | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. | I have a family member or friend who has attempted suicide | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. | I have a friend or family member who as committed suicide | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. | <u>I have made additional preparations for dying</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. | I feel nervous and jumpy much of the time. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. | <u>I feel afraid a good deal of the time.</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. | I have had "panic attacks" in the past. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. | <u>I find it difficult to sit still and generally feel anxious.</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. | I sometimes drink alcohol or use drugs to calm my nerves. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. | <u>I sometimes drink alcohol or use drugs to help me sleep.</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. | I think I may abuse alcohol. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. | <u>I think I may abuse drugs – recreational or prescription..</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. | I wonder if I may be "out of control" about something in my life. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. | I am concerned that I may be compulsive about something in my life. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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Office Policies and General Information
Agreement to Provide Psychotherapy/Consultation Services

Please read carefully and initial each page at the bottom.

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CONFIDENTIALITY: All information disclosed within psychotherapy sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without the client's written permission, except where disclosure is required by law.

Disclosure required by law: Some circumstances requiring disclosure are when there is reasonable suspicion of child, dependent, or elder abuse or neglect; when a client presents a danger to self, others, property, or is gravely disabled.

Disclosure may be required by law: Disclosure may be required pursuant to a legal proceeding. Placing your mental status at issue in litigation initiated by you, may give the defendant the right to obtain the psychotherapy records and/or testimony by Mr. Carroll. In couple and family therapy, or when different family members are seen individual, confidentiality and privilege do not apply between the couple or among family members. Mr. Carroll will use his clinical judgment when revealing such information.

Health Insurance: Your health insurance carrier may require confidential information to process a claim. Although only the minimum necessary information will be communicated to the carrier, Mr. Carroll has no control or knowledge over the use or disclosure of such information once it is in the possession of the insurance companies.

FEES AND PAYMENT: Payment for the therapy fee of \$125 per 45 minute session is expected before each session and may be made by cash, check, or credit card. The ninety minute Initial Consultation charge is \$160 and will be billed to your credit card or paid by check at the time you schedule the appointment. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, and other miscellaneous services are charged at the same rate. Notify Mr. Carroll immediately should problems arise during the course of therapy regarding your ability to make timely payments. For your convenience, we offer our "Easy Pay" arrangement wherein your credit card is automatically billed at the time of each therapy session.

Insurance: Mr. Carroll bills clients directly for services. Clients are provided the documentation required for requesting reimbursement from the insurance company. This is done on a monthly basis unless different arrangements are documented. This practice enhances confidentiality and helps contain your psychotherapy costs. We strongly recommend contacting your insurance carrier in advance if you intend seeking insurance reimbursements.

Cancellations/Rescheduling/Late Arrivals: Twenty-four hour notice is required to avoid charges for scheduled appointments. Mr. Carroll strives to remain on schedule and will assume at 15 minutes after the appointed time that you do not plan keeping that appointment.

TELEPHONE AND EMERGENCY PROCEDURES: (In life and death matters go directly to an hospital emergency room or call the police.) We maintain 24 hour telephone service and Mr. Carroll checks his messages several times per day; however, if you have not heard from him in what seems a reasonable time, it is advisable to call again. Clearly state the existence of a crisis if there is one.

Emergencies: If there is an emergency during our work together, or after termination where I become concerned about your personal safety, the possibility of your injuring someone else, or about your receiving proper psychiatric care, I will do whatever I can within the limits of the law to avoid such incidents and may contact the person whose name you have provided in the biographical information.

YOUR RIGHT TO REVIEW RECORDS: You have the right to review or receive a summary of your records, except in limited legal or emergency circumstances or when Mr. Carroll assesses that releasing such information might be harmful in any way. In such case, Mr. Carroll will provide the records to an appropriate mental health professional of your choice.

CONSULTATION: Mr. Carroll consults regularly with other professionals regarding clients; however, client's name or other identifying information are never mentioned, and anonymity and confidentiality are fully maintained.

THE PROCESS OF THERAPY/EVALUATION/CONSULTATION: Participation in therapy/consultation can result in a number of benefits to you,

including improving interpersonal relationships, and resolution of the concerns that led you to therapy. Psychotherapy requires the active involvement, honesty, and openness in order to change thoughts, feelings, and/or behavior. In the course of psychotherapy, remembering or talking about unpleasant events, feelings, and thought can result in considerable discomfort and strong feelings of anger, sadness, fear, etc; or the experience of anxiety, depression, insomnia, etc. Additionally, challenging your assumptions, perceptions, and beliefs may cause discomfort, also. With couples and families, the changes that occur in one client may result in discomfort for another, and generally couples and families do better if all are involved in psychotherapy. Change will sometimes come quickly, but most often, it is slow and gradual, and there is no guarantee that psychotherapy will yield the intended results.

DISCUSSION OF TREATMENT: Within a reasonable period of time and upon your request, Mr. Carroll will discuss his working understanding of the problem. You also have the right to ask about other treatment options and their risks and benefits. If I believe there are other treatments from which you could benefit, I will offer those suggestions or recommendations.

TERMINATION: Mr. Carroll does not accept clients he does not believe he can help, and will offer referrals if that seems advantageous, and will participate in transition to another mental health professional if needed. You have the right to terminate treatment at any time and are encouraged to discuss termination plans well in advance.

DUAL RELATIONSHIPS: Therapy never involves sexual relationships. Business or social relationships which might impair Mr. Carroll's objectivity, clinical judgment, therapeutic effectiveness, or which might be exploitative in nature are not tolerated.

MEDIATION AND ARBITRATION: Disputes arising out of or in relation to the agreement to provide psychotherapy/consulting services shall first be referred to mediation, before, and as a pre-condition of the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Mr. Carroll and the client. The cost shall be divided equally unless otherwise agreed. In the event the mediation is unsuccessful, any unresolved controversy related to this agreement shall be submitted to and settled by binding arbitration in Harris county, Texas in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding, the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Mr. Carroll can use legal means (court, collection agency, etc) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum and for attorneys fees. In the case of arbitration, that sum will be determined by the arbitrator.

LITIGATION LIMITATIONS: Due to the sensitive nature of the disclosures required in the therapeutic process, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc) neither the client nor his/her attorney, nor anyone else acting on your behalf call on Mr. Carroll to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

I understand and agree to the above policies and conditions of therapy as stated above and have received a copy of the Health Information Portability and Accountability Act (HIPAA).

| | | |
|---------------------|------|-----------|
| Client Name (Print) | Date | Signature |
|---------------------|------|-----------|

| | | |
|---------------------|------|-----------|
| Client Name (Print) | Date | Signature |
|---------------------|------|-----------|

Health Information Portability and Accountability Act

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 as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required National Privacy Policy and you may have a copy of this to read and refer to it for more information. However,

we can't cover all possible situations so please talk to our Privacy Officer (see the end of this pamphlet) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities which are called, in the law, health care **operations**. After you have read this NPP we will ask you to sign a **Consent Form** to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which 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 have the right to 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. You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must 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 NPP we will post the new version in our waiting area and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the 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.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer, Tony Carroll, LCSW, who can be reached by phone at 713 527-0000.

The effective date of this notice is _____

Also, you may have other rights which are granted to you by the laws of our state and these may be the same or different from the rights described above. I will be happy to discuss these situations with you now or as they arise.

| | | |
|---------------------|---------------|-----|
| Patient/Client Name | Date of Birth | SS# |
|---------------------|---------------|-----|

I hereby acknowledge I have received and have been given a copy of Tony Carroll, LCSW's Notice of Privacy Practices. I understand that I can contact Mr. Carroll, if I have questions related to the Privacy Practices.

Tony Carroll, LCSW, 1006 Missouri Street, Houston, Texas 77006, 713 527-0000

| | |
|-----------------------------|------|
| Signature of Patient/Client | Date |
|-----------------------------|------|

_____ Patient/Client Refuses to Acknowledge receipt:



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| | |
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| Signature of Patient/Client | Date |
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