



## **Counselor Limits of Confidentiality**

Your counselor recognizes that confidentiality is essential to effective counseling. In order for counseling to work best, you must feel safe about sharing your personal information with your counselor. Under most circumstances, all information about you, in written or verbal form, obtained in the counseling process (including your identity as a client) will be kept ethically and legally confidential. Information will not be disclosed to any outside person(s) or agency without your written permission except in certain situations, which include, but are not limited to:

- If you are determined to be in imminent danger of harming yourself or someone else.
- If you disclose abuse or neglect of children, the elderly, or a disabled person(s).
- If you disclose sexual misconduct by a mental health professional
- To qualified personnel for certain kinds of audits or evaluations
- In a criminal court proceeding
- In legal or regulatory actions against a professional
- In proceedings in which a claim is made about one's physical, emotional, or mental condition
- When disclosure is relevant to any suit affecting the parent-child relationship, which includes divorce and child custody deliberations.
- Where otherwise legally required

A court may not consider information that you also share, outside of counseling, willingly and publicly, protected or confidential. The above is considered a summary. If you have questions about specific situations or any aspects of confidentiality, please feel free to discuss your concerns with your counselor. You may also contact the <http://www.dshs.state.tx.us/counselor/default.shtm>.

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Client Signature

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MPAPLLC representative signature

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Date



## The Rights of Clients

1. You have the right to decide not to enter therapy with me. If you wish, I will provide you with the names of other good therapists.
2. You have the right to end therapy at any time. The only thing you will have to do is to pay for any treatments you have already had. You may, of course, have problems with other people or agencies if you end therapy—for example, if you have been sent for therapy by a court.
3. You have the right to ask any questions, at any time, about what we do during therapy, and to receive answers that satisfy you. If you wish, I will explain my usual methods to you.
4. You have the right not to allow the use of any therapy technique. If I plan to use any unusual technique, I will tell you and discuss its benefits and risks.
5. You have the right to keep what you tell me private. Generally, no one will learn of our work without your written permission. There are some situations in which I am required by law to reveal some of the things you tell me, even without your permission, and if I do reveal these things I am not required by the law to tell you that I have done so. Here are some of these situations:
  - a. If you seriously threaten to harm another person, I must warn that person and the authorities.
  - b. If a court orders me to testify about you, I must do so.
  - c. If I am testing or treating you under a court order, I must report my findings to the court.
6. If I wish to record a session, I will get your informed consent in writing. You have the right to prevent any such recording.
7. You have the right to review your records in my files at any time, to add to or correct them, and to get copies for other professionals to use.

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Client Signature

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MPAPLLC representative signature

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Date



## HIPAA 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 of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. 'Protected health information' is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. 1. Uses and Disclosures of Protected Health Information Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law . Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services from insurance companies. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include:

- If you are determined to be in imminent danger of harming yourself or someone else
- If you disclose abuse or neglect of children, the elderly, or a disabled person(s).
- If you disclose sexual misconduct by a mental health professional
- To qualified personnel for certain kinds of audits or evaluations
- In a criminal court proceeding
- In legal or regulatory actions against a professional
- In proceedings in which a claim is made about one's physical, emotional, or mental condition
- When disclosure is relevant to any suit affecting the parent-child relationship, which includes divorce and child custody deliberations.
- Where otherwise legally required

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the law. Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization. Your Rights Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information

for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction



Mental Health Professionals

requested and to whom you want the restriction to apply. Your therapist is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before May 15, 2009. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number (713.689.8252).

I have read the notice listed above.

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Client Signature

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MPAPLLC representative signature

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Date





3.  
What ideas do you have about the cause(s) of these problems?


4.  
What will you have changed about your feeling, thoughts, and behaviors when you have found reasonable solutions to you problem or problems? How will your life be different?


5.  
What kinds of things do you feel we might be able to do for you to help you?


**B. Previous Treatment**

What previous experiences have you had with psychological or psychiatric treatment?		
Dates	Therapist or Institution	Nature of Problem

Do you currently see a psychiatrist?	If yes, complete below.
Psychiatrist's name and phone number:	
PSYCHIATRIC MEDICATIONS (currently taking)	
Medication	Dosage Times per day Reason Prescribed by

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Client Signature

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MPAPLLC representative signature

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Date

