Shine Sparrow
THERAPY

INTAKE FORM

Please fill out the following to the best of your knowledge. Once completed, your counselor will meet with you to discuss the information and review counseling services and Shine Sparrow Therapy policies.

Adult Information

Name: ______________________ D.O.B.: __________ Gender Identity: __________

Spouse/Partner: No ☐ Yes ☐ (complete section below) Child(ren) from a previous relationship: No ☐ Yes ☐

Employer: ____________________ Occupation: ____________________

Home Address: ______________________ Preferred Phone: ______________

City: ______________ State: ______ Zip: ________ Email: ____________________

Partner Information

Name: ______________________ D.O.B.: __________ Gender Identity: __________

Spouse/Partner: No ☐ Yes ☐ (complete section below) Child(ren) from a previous relationship: No ☐ Yes ☐

Employer: ____________________ Occupation: ____________________

Home Address: ______________________ Preferred Phone: ______________

City: ______________ State: ______ Zip: ________ Email: ____________________

Family Information

Names of all Children at Home	DOB	School Attended/Grade

Names of Children NOT at Home	DOB	School Attended/Grade

Are there other adults residing at the family home? No ▢ Yes ▢ (please complete section below if yes)

Name: ______________________________ D.O.B.: __________ Gender Identity: __________

Relationship to Family: ______________________________

Name: ______________________________ D.O.B.: __________ Gender Identity: __________

Relationship to Family: ______________________________

Emergency Contact Information

Name: ____________________ Relationship: ______________ Phone: ______________

Name: ____________________ Relationship: ______________ Phone: ______________

Name: ____________________ Relationship: ______________ Phone: ______________

Reason for Visit

Please share why you are considering counseling:

____

____

____

____

Breifly describe any special situations, e.g. divorce, loss of job or relationship, custody issues, adoption, foster care, ongoing CPS involvement, loss of a loved one, etc.

____

____

____

____

What are your goals and hopes for the counseling process?

____

____

____

____

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If you could change anything about your relationship with yourself, partner, or family, what would it be?

How did you hear about Shine Sparrow Therapy?

Spiritual and Cultural

Is there anything you feel is important for your counselor to know about your culture, spirituality, or religion? If yes, please explain.

Family History

Is there a family history of…	Yes	No	Whom/In what circumstance?
Drug use/abuse	☐	☐	
Alcohol use/abuse	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
ADHD	☐	☐	
Autism	☐	☐	
Self Harm/Suicide	☐	☐	
Other Mental Health Concerns	☐	☐	
Physical/Mental/Verbal Abuse	☐	☐	

Stressors

Before completing the section on stressors, please be advised that all personnel of Shine Sparrow Therapy are obligated to report suspicious of abuse of a child, abuse of an individual who is age 65 or older, or abuse of an individual who is differently abled to Child Protective Services or Adult Protective Services as mandated by Texas Law. Please review the attached confidentiality policy for more information.

Below is a list of stressors that you or your children may have experienced. Please check all that apply, or leave blank if you choose not to answer.

	No	Yes	If yes, please explain
Grief over loss or death	☐	☐	______
Separation/ Divorce	☐	☐	______
Marital Conflict	☐	☐	______
Family/Domestic Violence	☐	☐	______
Moving (home, work, school)	☐	☐	______
Financial Stress	☐	☐	______
Out of home placement of a Child	☐	☐	______
Change of Primary Caregiver	☐	☐	______
Serious Injury or Medical Illness	☐	☐	______
Car Accident	☐	☐	______
Natural Disaster	☐	☐	______
Arrest or Incarceration	☐	☐	______
Crime Victim	☐	☐	______
Other Trauma or Stressor	☐	☐	______

Closing

Is there anything else that you feel is imporant to know that has not been covered? Do you have any questions or concerns?

______

______

______

______

Client Signature ______ Date ______

Client Signature ______ Date ______

Intake Staff Signature ______ Date ______

FEES, PAYMENT AND ATTENDANCE POLICY

Fees

The fees at Shine Sparrow Therapy are as follows:

» **Individual Intake Session** - 80 minutes - $150*
» **Individual/Couple/Child Session (any modality)** - 50 minutes - $100
» **Individual/Couple/Child Session (any modality)** - 80 minutes - $150
» **Phone Consults** - $25/15 min rounded up to nearest 15 minute increment, free if less that 15 minutes

**If client chooses not to return, no charge for intake session*

Initial: _______

Court Fees

In the event that a counselor at Shine Sparrow Therapy is asked to respond to a subpoena, attend a deposition or testify in a court case on behalf of the client or in a court case in which the client is involved in any way, then the following fees shall apply:

» $200 per hour, rounded up to the nearest one-quarter of an hour, for all activities associated with the response/deposition/court appearance, including, but not limited to: research; reviewing materials, drafting/reading emails, letters and documents;consultations and conferences, either in person or via telephone, with the client and/or client's lawyer on any matter pertaining to the response/deposition/court appearance; file copying; file preparation; travel time and time spent in court.

» Client shall reimburse Shine Sparrow Therapy for all expenses incureed as part of the response/deposition/court appearance, including but not limited to: mileage (per current IRS reccomendations), flight costs (if required), car rental cost (if required), hotel costs (if required), parking costs, fees to retain legal counsel, document photocopying costs, document shipping costs and all other associated expenses.

Please note that payment is due prior to the start of each session. For court fees, payment is due upon receipt of the invoice for those fees.

Initial: _______

Attendance Policy

Making changes through counseling can be difficult and depends on many things, one of which is attendance. Being present and prepared to actively participate in each session will increase the likelihood of making the changes you wish to see.

Client responsibility: If you need to cancel your scheduled cousneling appointment for any reason, please contact us at least 24 hours before your scheduled appointment begins. Any appointment cancelled within 24 hours of the scheduled time for that appointment shall be billed at the full session rate. If you are late to an appointment for any reason, please be aware your session will still end as scheudled and will not extend past the scheduled ending time.

Counselor Responsibility

If your counselor needs to cancel, every effort will be made to contact you as soon as possible before your scheduled appointment begins. Please keep in mind we will contact you at the number provided to us; if your contact information changes, please notify us as soon as possible.

Initial: _______

Please sign below to indicate you understand and accept the fees, payment, and attendance policy.

Client Signature ____________________ Date __________

Client Signature ____________________ Date __________

Counselor Signature ____________________ Date __________

Credit Card Authorization

I hereby authorize Shine Sparrow Therapy, PLLC, to charge my credit card on an ongoing basis for all fees incurred including: session fees, late cancellation/no show fees and court fees. I understand tand acknowledge that Shine Sparrow Therapy, PLLC, uses a PCI compliant, third-party credit card processing company to store credit card information and that by signing this form, I agree that Shine Sparrow Therapy, PLLC shall not be held liable for any breach of security of loss of information of for any fraudulent charges that may result from such a breach/ loss. I intend for thsi Authorization to remain in full force and effect until I revoke it in writing by notifying Shine Sparrow Therapy at 1207 B Fairbanks, Austin Texas, 78752. The revocation will not affect and actions taken before the receipt of the written revocation.

Client Signature ____________________ Date __________

Print Name ____________________

CONSENT TO PROVIDE EVALUATION AND/OR TREATMENT

Shine Sparrow Therapy, PLLC provides evaluation and counseling services to clients wishing to receive such services. Our services include but are not limited to, pre- and post- treatment evaluations; individual, family, and group counseling, and play therapy. We use evaluations so that we might better understand and measure the effectiveness of counseling programs and we use a variety of treatment programs to help individuals move toward the changes they wish to see in themselves and their families.

I, ____ (child's parent/gaurdian) consent to the following for my child ____ (child's name):

______ Participation in pre- and post- evaluations

______ Participation in treatment (counseling)

Please note, the success of the counseling process will depend on your active involvement as the child's parent of guardian to make the changes your counselor may recommend.

If you have any questions at any time about the evaluation and treatment programs used at Shine Sparrow Therapy, please do not hesitate to speak to your counselor.

By signing below, you are signifying that you consent to treatment. You are choosing to be an active, supportive part of the counseling process. You may withdraw your consent at any time.

Parent/Guardian Signature	Date
Parent/Guardian Signature	Date

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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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed without authorization by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members.

For Payment. We may use and disclose PHI without authorization so that we can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose without authorization, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the other categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law permits us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. With your authorization or in an emergency situation we may disclose information to close family members or friends directly involved in your treatment.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We will not send you fundraising communications without your authorization. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. In addition, authorization may be required for the use or disclosure of PHI if a more stringent state or federal law applies, such as substance abuse treatment information protected by 42 C.F.R. Part 2. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI (we will not sell your PHI); and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 1207 B Fairbanks Ave, Austin Texas 78752:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 1207B Fairbanks, Austin Texas 78752 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

The effective date of this Notice is September 01, 2016.

NOTICE OF RECEIPT OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

Name: ______________________________

Address: ______________________________

____

____

I hereby acknowledge that I received and have been given an opportunity to read a copy of Shine Sparrow Therapy's Notice of Privacy Practices. I undrstand that if I have any questions regarding the Notice or my privacy rights, Ican contact Shine Sparrow Therapy at 1207 B Fairbanks, Austin Texas, 78752 or call 512 - 387-1729.

______________________________ ______________

Signature Date

☐ A good faith attempt was made by Shine Sparrow Therapy Counseling Staff to provide "Notice of Privacy Practices." However, client refuses to acknowledge receipt of "Notice of Privacy Practices," owing to:

____

______________________________ ______________

Signature of Staff Member Date

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ELECTRONICS AND RECORDING POLICY

- It is important for you to be aware that computers, email, text, and other forms of electronic communication are potentially accessible by unauthorized individuals or organizations, which can compromise the privacy and confidentiality of information being stored or transmitted. Emails, texts, and all other forms of electronic communications are vulnerable to such unauthorized access owing to the fact that communication companies may have unlimited and direct access to all electronic communications that pass through their servers. While data and emails sent from a Shine Sparrow Therapy email address, and data on Shine Sparrow Therapy computers is encrypted, Shine Sparrow Therapy cannot guarantee the security of such communication once it leaves the Shine Sparrow Therapy domain.
- Shine Sparrow Therapy computers are equipped with a firewall, virus protection and passwords, and all confidential information is backed up on a regular basis to an encrypted hard-drive. Shine Sparrow Therapy emails are also encrypted per HIPAA standards.
- The text policy at Shine Sparrow Therapy is that text messages are only to be used to confirm or cancel appointment times. Please call if additional communication is needed.
- Please be advised that Shine Sparrow Therapy makes every effort to respond to emails and telephone calls within 24 hours during normal business hours/days with the exception of holidays or when Nurture Family Counseling offices are closed.
- Please do not use texts, email, voice mail, or faxes for emergencies. In the event of an emergency, please call 911 or proceed directly to your nearest emergency room or hospital.
- Please notify your therapist at Shine Sparrow Therapy if you would like to avoid or limit, in any way, the use of email, texts, cell phone calls, phone messages, or e-faxes for communications with your therapist. Please also note that you, as the client, accept all liability and risk if you choose to communicate confidential or private information electronically in any form and by signing this policy, you are indicating that you have read and accept this policy. Do not hesitate to let your therapist know if you have any questions regarding this communications policy.
- All audio and/or video recording of conversations, consultations, telephone calls or counseling sessions involving Shine Sparrow Therapy, PLLC personnel is strictly forbidden without the express written consent of the individual counselor being recorded.

Client Signature ____________________ Date ____________

Client Signature ____________________ Date ____________

Counselor Signature ____________________ Date ____________

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CONFIDENTIALITY POLICY

Your confidentiality is extremely important to us. We will not disclose any of your information, including your status as a client at Nurture Family Counseling, to anyone who is not an employee of Nurture Family Counseling or an approved supervisor for Nurture Family Counseling, without your written consent, with the exception of the following:

» If there is suspicion of abuse to a child, individual who is age 65 or older, or an individual who is differently abled, we will report our suspicions to Child Protective Services or Adult Protective Services as mandated by Texas law.

» If an individual wishes to harm himself or herself or another individual, we reserve the right to break confidentiality in order to seek help and protection for the individual and others.

» If client records are subpoenaed by a court of law, we are required to release these records as detailed in the subpoena.

Please keep in mind that your confidentiality extends beyond Nurture Family Counseling. Because we live in the same community, it is possible you may see an employee of Nurture Family Counseling outside of our office, such as at a restaurant or shopping center. To protect your confidentiality and privacy, employees will not acknowledge or approach you outside of Nurture Family Counseling. If you wish to initiate contact by approaching or acknowledging an employee, you are welcome to do so.

______________________________	______________
Client Signature	Date
______________________________	______________
Client Signature	Date
______________________________	______________
Counselor Signature	Date

CLIENT BILL OF RIGHTS

As a client of Shine Sparrow Therapy, you are entitled to the following rights:

1. You have the right to be treated with consideration and respect at all times, regardless of age, race, ethnicity, sexual orientation or identity, disability, or socioeconomic status. You have the right to share your thoughts and feelings without fear of judgment or harassment.
2. You have the right to ask questions and receive information in an understandable format about any services you receive.
3. You have the right to view the information kept in your files. When viewing such information is not advisable, we request a preliminary discussion before releasing your files.
4. You have the right to refuse any and all treatment to the extent permitted by law and to be informed of any consequences of such treatment.
5. You have the right to expect confidentiality and privacy concerning your status and participation at Shine Sparrow Therapy; this confidentiality is limited only by those exceptions listed in the "Confidentiality Policy."
6. You have the right to be advised if an employee at Shine Sparrow Therapy proposes to conduct research, which might affect your care or treatment. You have the right to refuse to participate in such research projects.

If you feel your rights have been violated, we encourage you to discuss your concerns with your counselor or other employee of Shine Sparrow Therapy.