Marilyn H. Stinson, PhD
Licensed Psychologist, LMSW, LPC
6208 W. Poly Webb Rd.
Arlington, Texas 76016
(817) 483-0020 / (817) 572-6676 Fax

ADOLESCENT INTAKE PAPERWORK

Adolescent intake paperwork: Please read and keep pages 1-3 that are general information about the counseling process and pages 7-9 about your right to privacy of your health care information (HIPAA). Prior to your adolescent's first appointment please **completely fill out pages 4-5** and **sign page 6 in the appropriate places**; then give completed pages 4-6 to the office staff.

NOTE: If a court order has been entered with respect to the conservatorship of your adolescent, or impacting your rights to give consent to mental health care and treatment, Dr. Stinson will not render services to your child until she has received and reviewed a copy of the most recent applicable court order.

About Dr. Marilyn Stinson

Marilyn H. Stinson, PhD is a Licensed Psychologist, Licensed Clinical Social Worker (LCSW) and a Licensed Professional Counselor (LPC). Dr. Stinson received her Master of Social Work from the University of Texas at Arlington and her PhD in Counseling Psychology from Texas Tech University. She provides individual, marital, and family counseling to adults and some adolescents.

Therapy Expectations

Your adolescent's first therapy session is a time to discuss the reasons you and your adolescent are seeking counseling and to gather adequate information to make a treatment plan for your adolescent's mental health care. The typical appointment schedule is once a week. I often assign homework to aid in healing. I take homework seriously and will ask your adolescent to be ready to initiate a discussion of homework at the next session. This is the adolescent's responsibility, not the parent's.

It is your responsibility to share any relevant information about your adolescent that could help me understand how best to help. If I do not directly ask you about a matter that could aid in treatment, please volunteer this information instead of waiting for me to ask. As treatment continues, I ask that parents/caregivers update me regularly on any information that would help me assess progress and continued treatment needs. If a topic comes up that I seem to not adequately focus on in that session or in future sessions, I encourage you and your adolescent to bring up the topic again as many times as you feel is necessary. Although a parent has the legal right to know all that is said in session, generally accepted standard of care asks that parents allow the adolescent to share in sessions without all information going back to the parent/caregiver. This creates an open and safe atmosphere for the adolescent to work through their and your concerns. I will be happy to give general updates. If during the course of treatment there is a safety issue or an important issue for your parenting/care giving of the adolescent, you will be apprised of the situation.

At the first session we will agree on a regular day and time for your appointment. Counseling sessions are 45 minutes. To maintain a secure frame, I will hold to that time. If you arrive late, we

will stop at the agreed time. If, on the other hand, I am running late you will be given your full appointment time. Fees and times may seem incidental to the actual therapy; but consistency aids in your adolescent's growth and healing and also contributes greatly to their sense of security. If the schedule is constantly changing, it is difficult to get much work done in therapy, and your adolescent will likely have subtle feelings of discomfort. If, however, these details remain solid and secure, your adolescent will feel a sense of health, safety, strength, and progress in healing and growth as a person.

As therapy progresses, there is often a "phasing out" process where therapy takes place less often as you begin to achieve goals of treatment (i.e. initially come weekly, then every other week and then monthly). If your adolescent continues therapy after our initial session, I ask for a commitment that treatment will not end without a face-to-face discussion. A phone call or cancellation of a session to end treatment is not in your adolescent's best interest and does not allow them to work through personal or therapeutic concerns. All clients are asked to come in to have a final termination session to discuss progress and gain closure to the counseling process. It is in your adolescent's best interest to have a positive and complete experience with therapy for their teen years and to set a positive expectation for any needed counseling in their adult life.

Unattended Children

Due to the nature of the therapeutic process, a quiet, peaceful and private atmosphere is necessary. Children left in the waiting area while parents are in session may be disruptive to other waiting clients, clients already in session and to our office staff. Therefore, it is our office policy that no children be left unattended in our offices at any time.

Cell Phone Use

To protect the privacy and therapeutic process of our clients and maintain the appropriate clinical atmosphere, please turn off your cell phone while in our offices. Should you need to make a call, you may step outside the building to make the call. However, it is best if you can postpone any calls until your appointment is concluded.

Fees and insurance

The cost of counseling is **$150.00** for a **45 minute** session. Checks, cash, and most credit cards are accepted at the time services are rendered. Parents are expected to pay the full fee at each session. If you have insurance that covers mental health care, we will be happy to file a claim to your insurance company, with your written permission and assignment of benefits. If your carrier denies payment for services rendered, you are responsible for any amount not covered, regardless of previous quotes by your insurance company.

Fees for Missed Appointments

Since your adolescent's progress in therapy is often affected by consistency in attending counseling sessions, it is strongly suggested that every effort is made to adjust schedules so you will be able to keep scheduled appointments. However, if you are unable to keep an appointment, please notify the office immediately at 817-483-0020 to cancel or reschedule with the office staff. If an appointment is scheduled for Tuesday through Friday and is cancelled or missed **without 24 hours' notice** you are responsible for the **full fee of $150**. If your appointment is on Monday, you must cancel before the same hour of your appointment on Friday. Third parties such as insurance companies and churches cannot be charged for any part of services not rendered. Timely and early cancellations allow your reserved time to be offered to someone else who could benefit from therapy.

After-Hours and Emergencies

I am NOT on 24 hour call. I do not see clients in the evening or on weekends. After-hours and weekends are reserved for my family. Any questions about scheduling will be answered by staff. Please wait until your adolescent's next scheduled session to discuss any personal issues or concerns. If you would like to speak to me before I see your adolescent, please let the office staff know. If there is a mental health emergency between sessions please call 911, go to the hospital or call your local crisis hotline.

Privacy and Confidentiality

You and your adolescent can expect privacy and confidentiality. Unless the laws and regulations of Texas require me to do so, under no circumstances may I even reveal the fact that your adolescent is a client except for the exceptions on limits of confidently outlined in the HIPPA information below. If you choose to allow information to be released to a professional, relative, friend or other person you have a relationship with to aid in your adolescent's care you must sign a release form.

Client/Therapist Relationship

A client and therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. I can best serve your adolescent's needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

Friending: I do not accept friend or contact requests from current or former clients or their parents on any social networking site (Facebook, LinkedIn, etc.). Adding clients or their parents as friends on these sites can compromise confidentiality and the therapeutic relationship.
Following: I will not follow any client or client's parent on Facebook, Twitter, Instagram, Tumblr, or other apps/websites. If there is online information to share, please bring it into the next sessions where it can explored.
Location-Based Services: To protect your privacy, do not check-in at my office on Facebook, Foursquare, Google+, or any other location-based service. If you or your adolescent have enabled location services on your phone, check-ins on such services could make it possible for others to surmise you or your adolescent are a counseling client at my office location.

Duty to Warn/Duty to Protect

If an adolescent is in any physical or emotional danger to themselves or another human being, I will act to prevent such harm and, as needed, contact any person who is in a position to prevent harm including but not limited to the person in danger. This includes any medical or law enforcement personnel deemed appropriate. If child abuse is suspected or reported by you or your adolescent, state law requires mental health professionals to report suspected child abuse to the appropriate authorities.

Other Questions

Please bring up any concerns you have in regard to your adolescent's therapy or the therapeutic process or in regard to payment matters. Treatment matters should be addressed to me as your adolescent's psychologist and payment matters to the office staff, unless there is a specific reason for me to be involved.

Marilyn H. Stinson, PhD
Licensed Psychologist, LMSW, LPC

ADOLESCENT INFORMATION

TODAY'S DATE:_____

NAME:_____ _____ _____**AGE:**____**D.O.B.:**_____
*(**First**)* *(Middle Initial)* *(Last)*

ADDRESS:_____ **CITY:** _____**STATE:**_____**ZIP:**_____

CELL #: (____**)**_____ **SOCIAL SECURITY #:**_____

SCHOOL:_____ **GRADE IN SCHOOL:**_____

MOTHER'S NAME:_____ **AGE:**_____**D.O.B.:**_____

OCCUPATION:_____ **EMPLOYER:**_____

EMAIL:_____ **SOCIAL SECURITY #:**_____
(PLEASE print <u>clearly</u>)

MOTHER'S CELL #: (___**)**_____ **WORK #: (**___**)**_____

FATHER'S NAME:_____ **AGE:**_____**D.O.B.:**_____

OCCUPATION:_____ **EMPLOYER:**_____

EMAIL:_____ **SOCIAL SECURITY #:**_____
(PLEASE print <u>clearly</u>)

FATHER'S CELL #: (___**)**_____ **WORK #: (**___**)**_____

SIBLINGS (*NAMES and AGES***):**_____

NEAREST RELATIVE *<u>NOT</u>* LIVING WITH YOU:_____**RELATIONSHIP:**_____

ADDRESS:_____**PHONE #: (**___**)**_____
(Street) *(City)* *(State)* *(Zip)*

ADOLSCENT'S PHYSICIAN:_____ **PHONE #: (**___**)**_____

CURRENT MEDICATIONS (*AND DOSES***):**_____

_____

_____

TODAY'S DATE: _____ *CLIENT'S NAME:* _____

DESCRIBE ANY IMPORTANT <u>MEDICAL</u> HISTORY, CHRONIC AILMENTS, OR OTHER HEALTH PROBLEMS YOUR ADOLESCENT IS EXPERIENCING:_____

_____

WHO REFERRED YOU TO THIS OFFICE?_____**RELATIONSHIP:**_____

PROBLEM(S) SEEKING COUNSELING FOR: _____

_____

PLEASE LIST COUNSELING GOALS: _____

_____

ANY PREVIOUS COUNSELING?____ (*If yes*) **WHOM DID YOU SEE?**_____

WHEN?_____**FOR WHAT PROBLEM(S) DID YOU SEEK COUNSELING?**_____

_____

PLEASE PLACE AN "X" BY ANY OF THE FOLLOWING THAT APPLY TO YOUR ADOLESCENT: *History of Physical Abuse_____, Sexual Abuse_____, Spiritual Abuse_____, or Emotional Abuse_____; Previous Mental Health Problems_____; Mental Illness in Family_____; Suicide Attempt(s) by Adolescent_____ or Family Members_____;*
Alcohol Use by Adolescent_____ Alcohol Abuse by Adolescent_____ or Family Member_____; Smoking Marijuana by Adolescent _____ or Family Member_____; Substance Abuse by Adolescent _____or Family Member_____;
Conflict with a parent_____; Conflict with a sibling_____; Conflict with a teacher_____; Conflict with peers_____;
Academic Problems _____: History of Academic problems_____. Behavioral Problems in School _____: History of Behavior Problems in School_____. Problems Making Friends _____, Problems Keeping Friends _____.
History of Hurting Animals_____; History of Starting Fires_____; History of Vandalism _____. History of Shop Lifting_____; Been Arrested_____. Family Member Been Arrested_____. Family Member in Prison_____.
Change in eating habits _____: Eating Problems _____; History of Eating Problems_____. Sleeping problems _____: History of sleeping problems_____. Obsessive Thoughts _____: Compulsive Behavior _____.
Please Explain any of the Above Marked items _____

_____

_____

_____

FAMILY PROBLEMS WHICH HAVE RECENTLY HAPPENED THAT AFFECT YOUR ADOLESCENT (i.e. money problems/strain on family finances, recent divorce, loss of a parent or grandparent or other close relative or friend, transportation problems, parent's personal problems, etc.): _____

_____

ANY OTHER PERTINENT INFORMATION? _____

_____

Thank you! We appreciate you taking time to fill out these forms thoroughly.
Please sign the appropriate places on the next page and give ***<u>pages 4-6</u>*** *to the office staff.*

Marilyn H. Stinson, Ph.D.
Licensed Psychologist, LMSW, LPC
6208 W. Poly Webb
Arlington, Texas 76016
(817) 483-0020 / (817) 572-6676 Fax

Acknowledgement of Receipt of HIPPA Information

I have received Dr. Marilyn H. Stinson's notice of "Policies and Practices to Protect the Privacy of Your Health Care Information" as well as general information on her practice.

_____ _____
Printed Name Signature

_____
Date

Assignment of Insurance benefits

If you think at any point you want our office to file claims with your insurance company please sign below.

I authorize your office to file claims, giving necessary information to my insurance. I assign benefits received that apply to my child's therapy sessions to Marilyn H. Stinson, PhD.

_____ _____
Printed Name Signature

_____
Date

==========

Consent to Treat Adolescent

By signing this Client Information and Consent Form as the parent/guardian of said child, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I am voluntarily agreeing for my adolescent to receive mental health assessment, treatment and services from Dr. Marilyn Stinson. I understand that I may stop such treatment or services at any time. (NOTE: If a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Dr. Stinson will not render services to your child until she has received and reviewed a copy of the most recent applicable court order.)

_____ _____
Name of client/minor child Date of Birth

_____ _____
Legal Guardian's Printed Name Signature

_____ _____
Date Relationship to child

Marilyn H. Stinson, Ph.D.
Licensed Psychologist, LMSW, LPC
6208 W. Poly Webb
Arlington, Texas 76016
(817) 483-0020 / (817) 572-6676 Fax

Policies and Practices to Protect the Privacy Of Your Health Information (HIPAA compliance)

This notice describes how psychological, mental health and any other information about you may be used and disclosed by me or my office and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*

– *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician, psychiatrist, or other health care provider.

- *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

- *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our clinic such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy or counseling notes. *"Psychotherapy or counseling notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on

that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against me with one of our state regulatory boards they have the authority to subpoena confidential medical or mental health information from us relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case**.**
- **Serious Threat to Health or Safety:** If it is determined that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, my office may disclose relevant confidential mental health information to medical or law enforcement personnel.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are getting treatment. Upon your request, we will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. When several patients are seen together in a therapy session (conjoint marital therapy, family therapy, etc.), without a subpoena from a court, we cannot release records from these sessions without a signed release from each adult present for that particular session. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Dr. Marilyn Stinson's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise our policies and procedures, we will provide an updated policy during your next visit or will mail a copy to your home address.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Dr. Marilyn H. Stinson, (817-483-0020).

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to Dr. Marilyn H. Stinson, 6208 W. Poly Webb Rd., Arlington, TX 76016.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services or Texas State Boards for my licenses (Psychology, Social Work, and Professional Counselor). I can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice is in effect and updated on July 1, 2018.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will either hand deliver the revised notice or mail it to you.