Integrated Healthworks

CAROL MAPP & ASSOCIATES, INC.
www.integratedhealthworks.com

WHAT TO EXPECT ON YOUR FIRST VISIT

Your first visit will consist of an interview between you and your Therapist in which the two of you will determine if the Therapist is a good fit for your counseling needs. If you and the Therapist agree that the Therapist is not right for you, the Therapist will refer you to another Therapist.

Fees and times may seem incidental to the actual therapy; but consistency in the temporal aspect of the frame contributes greatly to your sense of security. If your schedule is constantly changing, you will find that it is difficult to get any work done in therapy, and you will likely find yourself with subtle feelings of discomfort. If, however, these details remain solid and secure, your unconscious mind will see your Therapist as healthy, consistent, safe, strong, and devoted to your care.

SCHEDULE and TIME: The usual appointment schedule is once a week, though you and your Therapist may decide to meet every other week. At your first session, you and the Therapist should agree on a regular day and time for your appointment. Therapy sessions are typically 45 or 50 minutes. To maintain the secure frame, your Therapist will hold you to that time. If you arrive late, you still must stop at the agreed time. If, on the other hand, the Therapist is late, he/she should give you the full appointment time.

Your absences and lateness, as well as persistent silence, wanting to leave therapy, forgetting to pay or delaying payment, are often symptoms of "resistance", or fighting therapy. These may (or may not) reflect outside issues, and should be discussed with your Therapist. In most cases, you will be responsible for paying for any regularly scheduled sessions that you miss or cancel; you are not responsible for paying for sessions cancelled by the Therapist.

FEES: At your first session, the Therapist will inform you of the counseling fee. Fees vary *enormously* with the geographical area, the Therapist's qualifications, and the setting. Your health insurance may pay a portion of the fee. For your own mental health, you should keep your account current and paid up to date.

UNATTENDED CHILDREN: Due to the nature of the therapeutic process, a quiet, peaceful and private atmosphere is necessary. We have found that children left in the waiting area while parents are in session may be disruptive to other waiting clients as well as other clients in session, and may also be a distraction to our office staff. Therefore, it is our policy that no children be left unattended in our offices at any time. If you must bring your child(ren) with you to an appointment, please bring another adult (over age 18) to stay with them during your session. If you are unable to do so, please reschedule your appointment at a time when arrangements can be made for the care of your child(ren). Also, if your child is the client, the Therapist may wish to have a private consultation with you during the appointment time. In this instance, your Therapist will advise you in advance so that you may bring another adult with you to that appointment to wait with your child during the consultation.

CELL PHONE USE: To protect the privacy and therapeutic process of our clients and maintain the appropriate clinical atmosphere, we ask that you turn off your cell phone while in our offices. Should you need to make a call, you may either step outside the building to make the call, or use one of our office telephones. However, it is best if you can postpone any telephone calls until your appointment is concluded.

PRIVACY AND CONFIDENTIALITY: It should go without saying that you can expect absolute privacy and confidentiality. Under no circumstances may your Therapist ever reveal, without your permission, even the fact that you are a client, let alone any information at all about you or your case, to anyone. There may be instances when you choose to allow information to be released; in that case, your Therapist should obtain a signed consent form from you. If your therapy is provided as an employment benefit, there should be no requirement for the Therapist to report back to an employer about your progress. Managed health care programs increasingly intrude on this.

TERMINATION: In most cases, you will be the one to decide when it is time to stop therapy. This decision should be discussed in great depth with your Therapist to make sure you are not terminating prematurely as an unconscious reflection of some important issue in your life. If, however, you both agree that problems have been resolved and termination is appropriate, set a specific date for termination and stick to it. The frame should remain absolutely intact right to the end. After terminating, you have no further contact with your Therapist unless you experience some new emotional disturbance, in which case you can arrange another course of therapy.

Integrated Healthworks

CAROL MAPP & ASSOCIATES, INC.

www.integratedhealthworks.com

CLIENT INTAKE FORM

(Please Print)

Today's Date _____/_____/_____ **Therapist**_____

CLIENT INFORMATION

Client's Last Name First Middle	❑ Mr. ❑ Ms.	Marital Status: ❑Single ❑Married ❑Partnered ❑Other		
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑M ❑F
Street Address City State ZIP Code	Social Security - -	Home Phone No. ( )		
P.O. Box City State ZIP Code	Cell Phone No. ( )			
Occupation	Employer	Work Phone No. ( )		
Email Address:	Alternative Email Address:	On which phone numbers may we leave a message? ❑ Home ❑ Cell ❑ Work		
Referred to Provider by (Please check one box & list) ❑ Doctor _____ ❑Attorney _____ ❑Court ❑Insurance ❑Web Search ❑Family ❑Friend ❑Online Search ❑Other				

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )		
Email Address:			Cell Phone No. ( )		
Occupation	Employer	Employer Address	Work Phone No. ( )		
Is this client covered by insurance? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑ No	Total Annual EAPs allowed? _____			
Please Select Your Primary Insurance Provider	❑Aetna ❑Amerigroup ❑Beech Street ❑Blue Cross/Blue Shield ❑ChoiceCare ❑Champus ❑Cigna ❑Definity Health ❑First Health ❑HealthSmart ❑Humana ❑Magellan ❑Medicaid ❑Medicare ❑MHN/MHNet ❑PHCS ❑PMHS ❑Texas One Choice ❑TriCare ❑United Healthcare ❑Value Options ❑ Other _____ ❑ No Insurance / Self Pay				
What is the authorization number?					
Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $
Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____					
Name of Secondary Insurance (if any)	Insured's Name	Group #	Policy #		
Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____					

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

Integrated Healthworks

CAROL MAPP & ASSOCIATES, INC.

www.integratedhealthworks.com

CLIENT INTAKE FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. _____ will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance for services rendered.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

Integrated Healthworks

CAROL MAPP & ASSOCIATES, INC.
6208 West Poly Webb Road
Arlington, TX 76016

Phone: (817) 483-0020 **www.integratedhealthworks.com** **Fax: (817) 572-6676**

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

Professionals Include:
Maria Field, LPC-S Licensed Professional Counselor
Heather Dees, LPC Licensed Professional Counselor

CLIENT/THERAPIST RELATIONSHIP: You and your 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. Your Therapist can best serve your 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.

AVAILABLE SERVICES: _____ offers a wide array of counseling services, including individual, family, couples, and group services. We are staffed by skilled and experienced licensed professional counselors, and licensed clinical social workers. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: We provide short-term counseling designed to address many of the issues our clients are dealing with. Your first visit will be an assessment session in which you and your Therapist will determine your concerns, and if both agree that _____ can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your Therapist, services to you may be terminated.

The goal of therapy is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current Therapist are not a good fit, please discuss this matter with your Therapist to determine if transferring to a more suitable Therapist is right for you. If you and your Therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your Therapist. If you must cancel or reschedule your appointment, we ask that you call our office at 817-483-0020 at least 24 hours in advance, whenever possible. This will free your appointment time for another client.

FEE SCHEDULE:	Diagnostic & Evaluation Session (1st visit)	$175
	Regular Office Visits (50 minutes) (Individuals, Couples & Play Therapy)	$150
	Family Sessions (90 minutes)	$200
	Outside Office Work (inpatient visits, court, collaborative law services)	$200
	Written Reports (insurance companies, supervisors, etc. pro-rated at	$200
	Returned check fee per check	$30

A reasonable fee will be charged for copies of any records requested by the Client.

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, our office will file insurance claims for you, and we will

honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Monthly payment arrangements are available if needed for clients who have established a payment record for three months.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When your Therapist is out of town, you will be advised and given the name of an on-call Therapist.

CONFIDENTIALITY: _____ follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. To ensure your confidentiality, recording audio or video in your session without the written consent of your therapist is prohibited. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name	Telephone Number
_____	_____
_____	_____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, 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, _____ will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

_____	_____
Signature – Client/Parent	Date
_____	_____
Signature – Spouse/Partner/Parent	Date
_____	_____
Therapist	Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____	_____
Client/Parent	Date

I authorize the payment of medical benefits to the provider of services.

_____	_____
Client/Parent	Date

Carol Mapp and Associates
6208 West Poly Webb Road
Arlington, TX 76016
Phone: (817) 483-0020 **www.integratedhealthworks.com** **Fax: (817) 572-6676**

ADULT INFORMATION FORM

Name	Date of First Appointment	Therapist
Date of Birth	Age	Gender ❑Male ❑Female

MEDICAL HISTORY

Name of Primary Care Physician	Physician's Phone
Physician's Address	
Many managed care companies require that we interact with the client's physician to coordinate care. Do you give us consent to discuss your care with the above-named doctor? ❑YES ❑NO	
Please sign here for either answer	
Date of last medical evaluation	Date of next appointment

CURRENT MEDICATIONS BEING TAKEN

Name of medication	Dosage/Frequency	Start Date	Purpose	Prescribed By
1.				
2.				
3.				
4.				

HOSPITALIZATIONS

Have you ever been hospitalized for medical or psychiatric reasons? ❑YES ❑NO

Hospital	Month/Year	Reason
1.		
2.		

RECREATIONAL DRUG USE

Do you use recreational drugs? ❑YES ❑NO	If no, have you used previously? ❑YES ❑NO	If yes, when did you stop?
Type of Drug	How Much	How Often
1.		
2.		
3.		

ALCOHOL AND TOBACCO USE

Do you drink alcohol? ❑YES ❑NO	If no, did you drink previously? ❑YES ❑NO	If yes, when did you stop?
Type of Alcohol	How Much	How Often
1.		
2.		
Do you smoke cigarettes? ❑YES ❑NO	Do you smoke electronic cigarettes? ❑YES ❑NO	Do you use other forms of tobacco? ❑YES _____ ❑NO

OTHER MEDICAL HISTORY

Describe any important medical history, chronic ailments, or other health problems you experience:

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers?

❑YES ❑NO

If yes, please explain:

What was the last year of school you completed?

If you did not complete high school, please explain:

Please list schools currently attending, last attended, and graduated:

Currently attending:	Year(s)
Last attended:	Year(s)
Graduated:	Year(s)

How would you describe your current support network? (friends, relatives, etc.):

Please check all information which applies to your biological parents:

MOTHER	FATHER
❑ living	❑ living
❑ deceased	❑ deceased
❑ married	❑ married
❑ divorced	❑ divorced
❑ remarried ___ # of times	❑ remarried ___ # of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents?

❑YES ❑NO If so, whom? _____

SCHOOL AND FAMILY HISTORY (CONTINUED)

Where do your parents live?

Mother:

Father:

Describe your relationship with your mother while growing up:

Describe your relationship with your mother currently:

Describe your relationship with your father growing up:

Describe your relationship with your father currently:

List first names and ages of brothers and sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)

Describe any family problems which occurred while growing up relating to:

Alcohol / drug abuse:

Sexual / physical / emotional abuse:

MARITAL HISTORY

Relationship status: ❑ Single / never married ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Partnered

If currently married, when were you married?	If living with someone, how long?

Please list your children:

Name	Age	Relationship (biological/step)	Lives With

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

❑ sad	❑ anxious	❑ depressed	❑ frightened	❑ guilty	❑ angry	❑ ashamed	❑ aggressive	❑ resentful
❑ worthless	❑ tearful	❑ irritable	❑ confused	❑ extreme ups/downs	❑ jealous	❑ hopeless	❑ helpless	❑ other

Describe any other feelings you have had:

What activities or hobbies do you participate in?

Do you participate in regular exercise? ❑YES ❑NO
Describe:

Describe your current working environment:

Have you had any change in sleeping habits? ❑YES ❑NO
Describe:

Have you had any change in eating habits? ❑YES ❑NO
Describe:

Have you ever **considered suicide** in connection to your **current** problem? ❑YES ❑NO
If so, please give a brief description with dates:

Have you ever **considered suicide** in the **past**? ❑YES ❑NO
If so, please give a brief description with dates:

Have you **attempted suicide recently** or in the **past**? ❑YES ❑NO
If so, please give a brief description with dates:

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? ❑YES ❑NO
If yes, please explain:

Have you ever **considered homicide** in the **past**? ❑YES ❑NO
If yes, please explain:

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.):

THOUGHTS: Please check any of the following that apply to you:

- ❑ I sometimes hear voices even though no one nearby is talking to me.
- ❑ I sometimes feel that forces outside of me control me.
- ❑ I sometimes feel that other people control my thoughts.
- ❑ I sometimes have the same thought over and over and cannot control it.
- ❑ I sometimes feel that someone is out to hurt me or do something against me.
- ❑ I am sometimes unable to control my behavior.

Please explain:

OTHER INFORMATION

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your therapy goals:

THANK YOU!

Carol Mapp and Associates, INC DBA as Integrated Healthworks
6208 West Poly Webb Road
Arlington, TX 76016

Phone: (817) 483-0020 www.integratedhealthworks.com **Fax: (817) 572-6676**

CONSENT TO USE PHI FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

With my consent, Carol Mapp and Associates may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Carol Mapp and Associates Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Carol Mapp and Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer: Carol Mapp, LCSW at:

Carol Mapp and Associates, INC

6208 West Poly Webb Road

Arlington, TX 76016

With my consent, Carol Mapp and Associates may call my cell phone or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care. With my consent, Carol Mapp and Associates may mail to my home or other designated location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential.

With my consent, Carol Mapp and Associates may e-mail to me my appointment reminder cards and patient statements. I have the right to request that Carol Mapp and Associates restrict how it uses or discloses my PHI to carry out TPO. However, the practice is required by state statutes to agree to my requested restrictions, unless in extenuating circumstances allowed by law.

By signing this form, I consent for Carol Mapp and Associates to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Carol Mapp and Associates may decline to provide treatment to me.

Signature of Patient or Legal Guardian Date

_____ _____

Print Name of Patient

_____

Staff Member Signature

_____

Carol Mapp and Associates, INC DBA as Integrated Healthworks
6208 West Poly Webb Road
Arlington, TX 76016

Phone: (817) 483-0020 www.integratedhealthworks.com **Fax: (817) 572-6676**

CONSENT FOR RELEASE OF INFORMATION TO INSURANCE COMPANY

A request for records or information has been received by my Therapist, _____. I hereby consent and authorize _____ to provide _____ Insurance Company with the document or information attached to this consent form as Exhibit A, consisting of ____ pages.

I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and information requested by my insurance company, and hereby release _____ and his/her staff from any and all liability arising from release of the information and records requested.

Signature of Patient or Legal Guardian Date

_____ _____

Print Name of Patient

_____

Date of Birth

_____

Social Security Number

_____

Address

_____

City, State, ZIP

_____

Telephone Number

_____

Staff Witness Signature

_____

Carol Mapp and Associates
6208 West Poly Webb Road
Arlington, TX 76016

Phone: (817) 483-0020 **www.integratedhealthworks.com** **Fax: (817) 572-6676**

SOCIAL MEDIA POLICY

This document outlines my office policies related to use of social media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to interactions that may occur between us on the Internet. Please discuss any questions or concerns you may have with your therapist.

Separate Accounts
Your therapist holds separate and isolated accounts to be used for the sole purpose of professional matters regarding Carol Mapp and Associates. These accounts are separate from any personal accounts held by therapist as an individual.

Email
Please use email to contact me for administrative reasons only (modifying appointments, billing information, etc.). Please remember that if you email content related to our counseling sessions, it is not completely secure or confidential. Any emails I receive from you and any responses I send to you become a part of your mental health record.

Text Messages
Please do not send text messages, unless otherwise agreed upon. Any text message I receive from you becomes a part of your mental health record.

Friending
I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Adding clients as friends on these sites can compromise your confidentiality and our therapeutic relationship.

Following
I will not follow any client on Facebook, Twitter, Instagram, Tumblr, or other apps/websites. If there is content you wish to share from your online life, please bring it into our sessions where we can explore it together.

Search Engines
It is not a regular part of my practice to search for clients on Google, Facebook, or other searchable sites.

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 have enabled location services on your mobile phone, check-ins on such services could make it possible for others to surmise you are a counseling client at my office location.

(Printed name of client)

(If child is a minor, signature of parent or legal guardian) (Date)

(Signature of client if 18 years or older) (Date)

(Staff Witness) (Date)

Carol Mapp and Associates, INC DBA Integrated Healthworks
6208 West Poly Webb Road
Arlington, TX 76016

Phone: (817) 483-0020 **www.integratedhealthworks.com** **Fax: (817) 572-6676**

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, which may identify you and 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. 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 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. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. 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, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, 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. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of 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.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order

- 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.

Verbal Permission. We may 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.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Carol Mapp, LCSW at 6208 West Poly Webb Road, Arlington, TX 76016

- **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 may be 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. We may charge a reasonable, cost-based fee for copies.
- **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.
- **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 medical matters in a certain way or at a certain location.
- **Breach Notification**
  If there is a breach of unsecured protected health information 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 Carol Mapp, LCSW, our Privacy Officer, at 6208 West Poly Webb Road, Arlington, TX 76016, 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 03-01-2018

Carol Mapp and Associates, INC DBA Integrated Healthworks
6208 West Poly Webb Road
Arlington, TX 76016

Phone: (817) 483-0020 **www.integratedhealthworks.com** **Fax: (817) 572-6676**

NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Patient/Client Name:_____
DOB: _____ SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Carol Mapp and Associates DBA Integrated Healthworks Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at:

Carol Mapp, LCSW
Privacy Officer
Carol Mapp and Associates
6208 West Poly Webb Road
Arlington, TX 76016

_____
Signature of Patient/Client

_____
Signature or Parent, Guardian or
Personal Representative*

_____
Date

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ Patient/Client Refuses to Acknowledge Receipt:

_____
Signature of Staff Member Date