Integrated Healthworks

6208 West Poly Webb Road Arlington, TX 76016

Telephone: 817-483-0020 Fax: 817-572-6676

CO-PARENT COUNSELOR INFORMATION SHEET

Today's Date: _____ Co-Parent Counselor: Carol Mapp

Client Information

Name:_____

Birth date: _____ DL#: _____ State _____

Address: _____

City/State: _____ Zip: _____

Home/Mobile Phone where we may leave a message:

_____

May we contact you by email? No: _____ Yes: _____ If so,

Email Address(s): _____

Employer: _____

Other Parent's name: _____

How long were you and the other parent together? _____

If married, when was your divorce final? _____

Attorney Information

Name: _____

Address: _____

City/State: _____ Zip: _____

Office Telephone: _____ Office Fax: _____

Email Address(s): _____

Legal Assistant Name: _____

Email Address: _____

Amicus Attorney Information

Name: _____

Address: _____

City/State: _____ Zip: _____

Office Telephone: _____ Office Fax: _____

Email Address(s):_____

Legal Assistant Name: _____

Email Address(s): _____

Ad Litem Attorney Information

Name: _____

Address: _____

City/State: _____ Zip: _____

Office Telephone: _____ Office Fax: _____

Email Address(s): _____

Legal Assistant Name: _____

Email Address(s): _____

Have You Ever Used Any of the Following Other Court Related Interventions?

Parent Facilitator	past _____	present _____	when: _____
Parent Coordinator	past _____	present _____	when: _____
Custody Evaluator	past _____	present _____	when: _____
Social Study	past _____	present _____	when: _____
Court Ordered Therapy	past _____	present _____	when: _____
Educational Consultant	past _____	present _____	when: _____
Supervised Visitation	past _____	present _____	when: _____
Reunification Therapy	past _____	present _____	when: _____

Informed Consent for Co-Parent Counseling

I voluntarily agree to participate in Co-Parent Counseling with Carol Mapp, LCSW. I understand and acknowledge that Co-Parent Counseling is not psychotherapy. By signing this Informed consent for Co-Parent Counseling, I acknowledge that I have both read and understood all the terms and information contained herein. I will have opportunity to ask questions and seek clarification of anything that is unclear to me.

Client Signature: _____ Date: _____

Professional Relationship

It is imperative that your relationship with your Co-Parent Counselor remain solely a professional one. Personal and business relationships would undermine the effectiveness of the professional one. The successful completion of your case is important to me, but I am unable to have a personal or business relationship with you. Therefore, gifts, bartering, and trading services are not appropriate.

CONFIDENTIALITY:

In Co-Parent Counseling, there is no expectation of confidentiality. While a Co-Parent Counselor will not discuss your case with anyone not connected with your case, there are specific and limited circumstances when the Co-Parent Counselor may discuss your case with people not associated with your case:

1) The client authorizes release of information, by signature, as specified in the Release of Information Form.
2) Where there is a clear threat to do serious bodily harm to yourself or others.
3) Where there is reason to suspect the occurrence of abuse or neglect of a child, a dependent adult, or a person with developmental disabilities.
4) In response to a subpoena that is associated with a regulatory complaint or in response to a subpoena from a court of competent jurisdiction.

I have read and understand the Notice of Privacy Practices provided to me by Carol Mapp, LCSW

Client Signature: _____Date: _____

Payment for Services:
Forms of Payment: Cash, check, Visa, Mastercard, Discover, and American Express are accepted as payment. For your convenience, we have an online payment portal at www.carolmapp.net\billing

Unpaid account: If your account is unpaid and there is no written agreement for a payment plan, I may have to use legal means to collect the debt. The office will make every effort to work with you.

Client Signature: _____Date: _____

Cancellations/No Shows

If you must cancel an appointment for any reason, please give at least 24-hour notice. Otherwise, you will be billed the regular session fee. You may cancel an appointment 24 hours before your scheduled appointment via telephone at 817-483-0020 or email at carol@cmappassociates.com.

If you are running late to a session, please contact the office immediately. In the event a client arrives 20 minutes late or more for a session, the session will be rescheduled.

If you are the other parent no-shows an appointment, the parent who no-shows will be held responsible for 100% of the appointment fee.

Client Signature: _____ Date:_____

In the Event of Co-Parent Counselor's Death

I acknowledge that, in the event the undersigned Co-Parent Counselor becomes incapacitated or dies, it will become necessary for another Co-Parent Counselor to take possession of my file and records. By signing this information and consent form, I give my consent to allow another licensed mental health professional selected by the undersigned Co-Parent Counselor to take possession of my file and records and provide me with copies upon request or deliver them to a Co-Parent Counselor of my choice. I will select a successor Co-Parent Counselor within a reasonable time and will notify the appointed licensed mental health professional.

Children Information

Name /Birth Date/Age /Grade/School/ Current Living Arrangements

_____
_____
_____
_____
_____
_____
_____
_____

Does your child(ren) see a therapist? No: _____ Yes: _____ If so, who is the therapist?

_____

Others Living in the Home

Name/Birth Date/Age/Relationship to you

_____
_____
_____
_____
_____

Involvement of extended family members or significant others

_____
_____
_____
_____
_____

Who cares for your children when you are not at home?

Name: _____ Phone: _____

Name: _____ Phone: _____

Concerns about domestic violence?
No: _____ Yes: _____ If yes: Describe:

_____
_____
_____
_____
_____
_____

Were these concerns ever reported?
No: _____ Yes: _____ If so to whom and details of the report:

_____
_____
_____
_____
_____
_____

Concerns about neglect or sexual or physical abuse or the safety of your children?
No: _____ Yes: _____ If yes, please describe:

_____
_____
_____
_____
_____

Were these concerns ever reported?
No: _____ Yes: _____ If so to whom and details of the report:

_____
_____
_____
_____
_____
_____

Is there a pending hearing?
No: _____ Yes: _____ If so, when? _____

Past CPS cases? No: _____ Yes: _____ If so, please describe:

Current open CPS case? No: _____ Yes: _____ If so, please describe:

Concerns about substance abuse or alcohol problems?
No: _____ Yes: _____ If yes, please describe:

Were these concerns ever reported?
No: _____ Yes: _____ If so, to whom and details of the report:

Please describe your child(ren)-include information on special needs:

Has your child(ren) ever been hospitalized in an in-patient hospital?
No: _____ Yes: _____ If so, please describe with dates:

Please describe your relationship with your child(ren):

Please describe the other parent's relationship with your child(ren):

Please describe your style of parenting:

What do you have in common with the other parent?

What discipline plans are in place for your child(ren)?:

What discipline plans are in place with the other parent?

Please describe your strengths as a parent:

Please describe your weaknesses as a parent:

_____
_____
_____

Please describe the other parent's strengths as a parent:

_____
_____
_____

What would it be like to be a child in your family?

_____
_____
_____
_____
_____

Do you have any concerns regarding the mental health of the other parent? If so, please describe:

_____
_____
_____
_____
_____

What will the other parent say about you?

_____
_____
_____
_____

How do you and the other parent communicate? Check all that apply
Face-to-face: _____Email: _____ Text: _____
Our Family Wizard or other parent portal or app: _____

Please describe the communication between you and the other parent:

_____
_____
_____
_____
_____
_____

Please describe your involvement in your child's activities, both past and present (include extracurricular activities, school events, medical and dental appointments, etc.):

How are decisions made regarding extra curricular activities? Who pays for these activities and do you have problems agreeing on them?

How do you and the other parent make decisions regarding your child's education?

Please describe your current parenting time with your children, including days and times of exchange and who provides transportation:

Please describe your current work hours:

Any prior arrests for anyone in the family?
No: _____ Yes: _____ If yes, please describe:

Describe the conflict between you and the other parent:

_____
_____
_____
_____
_____
_____
_____

_____

Problematic co-parent behaviors that need addressing:

_____
_____
_____
_____
_____
_____
_____

Goals for Co-Parent Counseling:

_____
_____
_____
_____
_____
_____
_____

Any Other information that you would like to share with your Co-Parent Counselor

_____
_____
_____
_____
_____
_____

Parent Signature: _____
Date: _____

Co-Parent Counseling Contract
Agreement/Expectations

As of today, _____ I agree to the following Co-Parent Counseling program guidelines to supplement our stipulation or court order for the appointment of Co-Parent Counselor, Carol A. Mapp, LCSW:

CO-PARENT COUNSELING OVERVIEW

1. **I understand that Co-Parent Counseling is court ordered. There is no third-party reimbursement that will be expected. Although Co-Parent Counseling is a type of dispute resolution intended for high conflict families and uses mediation skills, it is not considered mediation or practice of law. I understand that the process of Co-Parent Counseling is non-confidential as it relates to any required testimony, status memos, or consultations with my attorney, court personnel, or case experts. The Co-Parent Counselor works as a neutral and objective party to assist both parents in resolving conflict in the best interest of their child(ren).** _____

2. I have reviewed and agree to the **fee breakdown** on page 3 of this contract. I recognize that I will be financially responsible for any time invested by our Co-Parent Counselor that is associated with our case. If an item fee is not included on the fee sheets, the fee will be determined by the Co-Parent Counselor's typical hourly rate. The Co-Parent Counselor has the discretion to determine how to split email, document review, or professional calls unless set forth by an order of the court_____

3. We will **schedule joint sessions** every other week unless the Co-Parent Counselor recommends more frequent appointments. As soon as we achieve our mutual goals, we will be moved to an "as needed basis" so we will not be required to schedule appointments unless we reach an impasse. _____

4. I understand that the Co-Parent Counselor will **document non-compliance** with any court order, program agreements, and guidelines. _____

5. I agree that any **documents or other material** which one parent gives to the Co-Parent Counselor will have a fee associated with the time involved reading or viewing the material. Furthermore, any documents provided to the Co-Parent Counselor will be made available to the other parent. I acknowledge that no such communication is confidential. This includes e-mail communication and text messages. _____

6. I acknowledge that the Co-Parent Counselor is a **mandated reporter**. The Co-Parent Counselor must report concerns of abuse or neglect of children, elderly, or disabled persons to the appropriate authorities. _____

7. I understand that the Co-Parent Counselor may communicate with **any professional involved with our case**, including our attorneys, case experts, or court personnel. The Co-Parent Counselor's fees apply to any communication that is completed. _____

8. I acknowledge that the Co-Parent Counselor can refer me to **other resources, evaluations, and therapeutic interventions** when needed in the best interest of the child(ren). _____

9. I agree that the Co-Parent Counselor may ask extended family, including stepparents, to attend any joint meeting if their attendance will help resolve the conflict in our case. _____

10. If I change attorneys for any reason, I will provide written notice to the Co-Parent Counselor. _____

EXPECTED PARENT BEHAVIOR

1.I will **not discuss any information shared during the Co-Parent Counseling process with our child(ren)** or with any individual who may intentionally or unintentionally share this information with our child(ren). Exceptions may be requested by the Co-Parent Counselor. _____

2. I will be **responsible for my own behavior** and not focus on the behavior of my co-parent. I understand that I am expected to make changes that benefit our child. _____

3. I will **encourage our child(ren) to respect** and love the other parent in both homes. _____

4. I recognize that I am expected to **work towards the future** rather than stay focused on the past or on blaming the other parent. _____

5. I will make child focused decisions and sacrifices as needed. I will stay solution **focused on our child rather than fight to "win**." _____

6. I understand that I am expected to **demonstrate respectful interactions** in spite of how I may be feeling towards the other parent. _____

7. I will take **responsibility for planning two parenting issues for each session** regarding matters that need to be resolved or discussed. _____

8. I will **not contact our Co-Parent Counselor after hours.** Co-Parent Counselor will make all efforts to return calls within 24 hours unless it is a holiday or if Co-Parent Counselor is out of the office for professional reasons or if it is scheduled vacation. If I need to reschedule, I can contact the office and leave a message. I will email and indicate the exact nature of the emergency. _____

9. I will **greet my co-parent**, no matter how I feel about them every time I see them and even when my child is not present. (This includes the waiting room) _____

10. I **will not block my child's contact** with the other parent either by phone or visitation unless there is an order in place to the contrary. I will ensure that my child returns any calls the other parent places to the child the same day whenever a voice message or text has been left for them. I will keep child calls and parent calls separate. _____

11. Above all, I will **use impulse control** and shield our child from parental conflict and all negative comments. _____

12. I will allow the child(ren) to express love for both parents in both homes. _____

13. I will "**consult" with my co-parent on all major non-emergency parenting decisions** rather than simply "inform" them regarding a unilateral decision. _____

14. I will **not schedule activities or appointments on the other parent's time** without prior agreement, with the exception of regularly scheduled appointments or extra-curricular activities. _____

15. I will **honor the current order and all new agreements** made in our joint sessions. I will comply with recommendations made by our Co-Parent Counselor. _____

16. I understand that **communication with the Co-Parent Counselor** is very important. Telephone consultations and individual meetings will be made at the discretion of the Co-Parent Counselor. Email is only used for short responses, scheduling purposes, or as otherwise indicated in a court order or report. _____

Co-Parent Counselor Responsibilities include:

Co-Parent Counseling is short-term solution-based coaching that finds solutions to the practical problems of Parenting.

A. Co-Parenting Counselor works as a neutral and objective party to assist both parents in resolving conflict in the best interest of their child(ren). ____

B. Co-Parenting Counselor coaches, arbitrates, and educates as needed. _____

C. Co-Parenting Counselor may be called upon as necessary to assist the family with any new conflicts until the child(ren) is(are) 18 years old. _____

D. Co-Parenting Counselor may also recommend resources and evaluations as he/she finds that action in the best interest of the child(ren). ____

E. Co-Parenting Counselor may communicate with any professional including the parents' attorneys. _____

F. Co-Parenting Counselor can refer to other sources and evaluations if needed. ____

G. For the safety of both parties, Co-Parent Counselor, and staff, firearms—concealed or openly carried are not permitted on the premises ____

Co-Parent Counseling Fee Breakdown

$250	60-minute individual intake or coaching session
$67.50	Per quarter hour for extended joint session
$250	Per hour for phone consult during business hours, billed in increments of 15 minutes (15 minutes = $50)
$275	Per hour for phone consult after business hours, billed in increments of 15 minutes (15 minutes=$62.50)
$275	Per hour for emergency phone call after hours, billed in increments of 15 minutes (15 minutes=$62.50)
$250	Per hour for reading and/or responding to email or text communication, billed in increments of 15 minutes
$250	Per hour for drafting status reports, parenting plans, and final reports, billed in increments of 15 minutes
$250	Per hour for phone calls and interviews with other professionals involved in case, billed in increments of 15 minutes
$250	Per hour for document review, billable in increments of 15 minutes

BUSINESS HOURS ARE MONDAY-THURSDAY 6:30am-4:00pm unless otherwise posted

I acknowledge that I will be billed for a joint session along with my co-parent's portion of the session if I am unable to control my behavior during the session. I will be responsible for my fee as well as my co-parent's fee for any cancellation made without 24-hour notice provided to both the Co-Parent Counselor and to my co-parent. In addition, I recognize that if I do not attend a scheduled session and have not provided notice, I will be responsible for my fee as well as my co-parent's fee. I understand that this fee applies regardless of who has been ordered to pay for the joint sessions. Payments can be made online at www.carolmapp.net/billing. Meetings will be suspended if a parent is not current with payment to the Co-Parent Counselor. _____

LITIGATION FEES:

In the event, the Co-Parent Counselor is subpoenaed by my attorney to testify or provide records, I shall be responsible **for all fees** associated with this time, including preparation time. The Co-Parent Counselor must receive a minimum of two weeks-notice before any testimony is required. A retainer shall be paid a minimum of seven days in advance of any deposition or court date. If records are subpoenaed, a minimum of seven (7) working days is required to produce the records. If the Co-Parent Counselor is required to testify by the Judge or Attorney, these fees shall be split equally unless otherwise ordered by the court.

$300	Per hour for file preparation for court or depositions, billed in increments of 15 minute.
$300	Per hour for document creation
$300	Per hour for attorney consultations
$300	Per hour for depositions
$300	Per hour for court testimony ($1200 for half day or $2400 for full day)
$300	Express Fee if subpoena received less than 72 hours before testimony required.

_____

COMPLAINTS

If a parent has a complaint about the Co-Parent Counselor or is dissatisfied with the performance of Co-Parenting Counselor, the parent is encouraged to work to resolve their differences. The following steps are to be followed in dealing with complaints:

Step 1: The parent will request an individual session with the Co-Parent Counselor to work through the difficulty.

Step 2: The parent will put the complaint into a written summary of one page or less and submit it to Carol Mapp, LCSW.

Step 3: A consultation meeting with the parent and the Co-Parent Counselor.

Step 4: The parent may request that the court appoint another Co-Parent Counselor. _____

CONCLUSION

The Co-Parent Counseling process may be concluded in the following three ways:

1. The process is successful and the parents agree that further meetings are not needed.

2. In the opinion of the Co-Parent Counselor, the process is not working due to non-compliance by one or both parents.

3. The Co-Parent Counselor withdraws because of concerns of personal safety or safety of any party. _____

I have read and understand all four (4) pages of this contract. I have been provided a copy of this contract for my records. If I have an attorney, it is my responsibility to provide him/her with a copy of this document. My signature below indicates my agreement with all four (4) pages of this Co-Parent Counseling Agreement/Expectation Contract.

_____	_____	_____
Print Name	Parent Signature	Date

_____	_____
Co-Parent Counselor	Date

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 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