Integrated Healthworks

6208 West Poly Webb Road Arlington, TX 76016

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

NON-COURT ORDERED CO-PARENT COUNSELING INFORMATION SHEET

Today's Date: _____ Provider_____

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: _____

Another Parent's name _____

How long were you and the other parent together? _____

Have You Ever Used Any of the Following Interventions?

Parent Facilitator	☐ past	☐ present	_____when
Parent Coordinator	☐ past	☐ present	_____when
Custody Evaluator	☐ past	☐ present	_____when
Social Study	☐ past	☐ present	_____when
Couple's Therapy	☐ past	☐ present	_____when
Educational Consultant	☐ past	☐ present	_____when
Supervised Visitation	☐ past	☐ present	_____when
Reunification Therapy.	☐ past	☐ present	_____when
Collaborative Services	☐ past	☐ present	_____when

Informed Consent for Co-Parent Counseling

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.

Available Services

Effective communication is founded on mutual understanding and rapport between clients and the Co parent counselor. It is my intent to convey the policies and procedures used in the counseling process and will be pleased to discuss any questions or concerns you may have.

Duties of a Co-Parent Counselor

1.) identifying disputed issues.
2.) reducing misunderstandings.
3.) clarifying priorities.
4.) exploring possibilities for problem solving.
5.) develop methods of collaboration in parenting:
6.) understanding parenting plans and reaching agreements about parenting issues to be included in a parenting plan and.
10.) and settling disputes regarding parenting issues and reaching a proposed joint resolution or statement of intent regarding those disputes.

Risks and Benefits

Co Parent counseling is beneficial, but as with any process, there are inherent risk. During the Co parent counseling process, you will have discussions about issues which may bring to the surface uncomfortable emotions. The benefits of Co parent counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved Co parent relationship, reduced conflict, and increased problem solving. I cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your individual and shared goals.

Communication with Co Parent Counselor

It is office policy to use email only for brief communication including scheduling of appointments and administrative purposes such as billing. Email is not a confidential form of communication, therefore Carol Mapp, LCSW chooses not to conduct services by email, and discourages the use of email communication between herself and clients. Longer contact is possible, by appointment, to address immediate or intermediate concerns. We would be happy to schedule an appointment to assist you. Please note that any email communication becomes a part of your record and may be shared should the documents be subpoenaed by the courts, or other governing agencies. I consent to receive communication by e-mail for the e-mail address I've provided. I may rescind my agreement in writing to Carol Mapp, LCSW.

Emergencies

If you have an emergency, please call 911 or go to your nearest emergency room. Please do not use my e-mail for emergencies, as I cannot assure, I will get your e-mail in a timely manner.

CONFIDENTIALITY:

Carol Mapp, LCSW follows all ethical standards prescribed by state and federal law. I'm required by practice guidelines and standards of care to keep records as prescribed by state and federal guidelines. While provider will not discuss details of your session with anyone, there are specific and limited circumstances when provider shall discuss 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.

If you Have any questions regarding confidentiality, you should bring them to the attention of the Co Parent counselor to discuss this matter further period by signing this information consent form, you are giving consent to the undersigned Co parent counselor to provide counseling services.

Complaints and Concerns

It is my endeavor to provide the most effective experience available to you. If at any time you feel that you and your Co parent counselor is not a good fit, please discuss this matter with me to determine if transferring to more suitable professionals right for you. If you decide that other services would be more appropriate, I will assist you in finding a provider to meet your needs.

Fees Schedule:

Co-Parent Counseling is billed at $250.00 per hour billed in increments of .25 hour.

Billable Services

Individual meetings (Paid solely by the parent incurring the expense unless other written agreement is made)

Conjoint Sessions (Each parent pays half)

Phone calls to client or professionals (Paid solely by the parent incurring the expense unless other written agreement is made)

Document creation (Each parent pays half)

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. If your ability to pay for services rendered changes, please speak with me directly.

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.

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 817-483-0020 or email Julie at julie@integratedhealthworks.com.

If you are running late to a session, please contact the office immediately by email to julie@integratedhealthworks.com or karen@integratedhealthworks.com In the event a client arrives 20 minutes late or more for a session, the session will be rescheduled.

If you or 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: _____

Communication With Counselor Between Sessions

It is my office policy to use email only for brief communication including scheduling of appointments and administrative purposes such as billing. Email is not a confidential form of communication, therefore Carol Mapp, LCSW chooses not to conduct services by email, and discourages the use of email communication between herself and clients. We would be happy to schedule an appointment with you to address immediate concerns. Please note that any email communication becomes a part of your record and maya be shared should the documents be subpoenaed by the courts, or other governing agencies.

In the Event of Provider's Death

I acknowledge that, in the event the undersigned provider becomes incapacitated or dies, it will become necessary for another provider 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 provider to take possession of my file and records and provide me with copies upon request or deliver them to a Co-parenting counselor of my choice or by order of the court. If appropriate, I will select a successor within a reasonable time and will notify the appointed licensed mental health professional.

Informed consent by signing this client information and consent form as the client and acknowledge that I have read, understood, and agreed to the terms and conditions contained in this form. I understand that coparent counseling is psychotherapy. I've given

appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to engage in this service of Co Parent counseling and understand that I may stop such services at any time.

I have read and understand the Informed Consent provided to me by Carol Mapp, LCSW

Client Signature: _____Date: _____

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? Yes ☐ **No** ☐

If so, when? _____

Current open CPS case Yes ☐ **No** ☐ **If so, please describe**

Past CPS cases? Yes ☐ **No** ☐ **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 ever been hospitalized in an in-patient hospital? Yes ☐ No ☐

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?

How has the present court matter affected your children?

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? Circle 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(ren)'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

What concerns do you have regarding your child(ren)

_____
_____
_____
_____
_____
_____

Goals for Co-Parent Counseling

_____
_____
_____
_____
_____
_____

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

_____
_____

Parent_____

Date_____

Co-Parent Counselor _____

Date_____

Integrated Healthworks DBA Carol Mapp and Associates, INC
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
Emergencies
National Security
Judicial and Administrative Proceedings
Law Enforcement
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
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 6001 Interstate 20 West suite 214 Arlington, TX 76017, 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 9-1-2014.

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, LCSW or Integrated Healthworks 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, INC DBA as Integrated Healthworks 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, LCSW and Carol Mapp and Associates, INC DBA as Integrated Healthworks 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, LCSW and her staff may call my cell phone 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, and any call pertaining to my clinical care. With my consent, Carol Mapp, LCSW or Carol or her staff may mail to my home or other designated location any items that assist in carrying out TPO, such as 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 reminders 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, INC 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, INC may decline to provide treatment to me.

Signature of Patient or Legal Guardian Date

_____ _____

Print Name of Client

_____

Staff Member Signature Date

_____ _____

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

Social Media Policy

This document outlines 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
Carol Mapp, LCSW holds separate and isolated accounts to be used for the sole purpose of professional matters. 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.

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

Online Information
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, Instagram, Twitter, or other searchable sites.

Location-Based Services
To protect your privacy, do not check-in at my office on any 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.

Client Signature_____ Date: _____

Therapist Signature_____ Date: _____