Dr. White and Associates, P.C.

2545 74th St., Lubbock, Texas 79423 dwatherapy.com (806) 780-0003 -Office (806) 780-0007 -Fax

Today's Date: _____

Client Information:

Name: _____ Sex: M F Age: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Employer/School: _____

Home Phone: _____ May a voice message be left at this number: Yes No

Cell Phone: _____ May a voice message be left at this number: Yes No

May a text message be sent to the cell number above: Yes No

Email _____ May a message be sent to your email: Yes No

Do you want appointment reminders sent to the above email address: Yes No

Do you want text reminders sent to the above cell number 24 hrs. before appt.: Yes No

Education Level: _____ Church you attend: _____

Relationship Status: (please circle) Single

Dating (how long? _____) Engaged (wedding date? _____)

Married (how long? _____) Separated (how long? _____)

Divorced (how long? _____) Widowed (how long? _____)

Spouse of above client OR Parent of a minor child: (circle one)

Name: _____ Sex: M F Age: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Employer/School: _____

Home Phone: _____ May a voice message be left at this number: Yes No

Cell Phone: _____ May a voice message be left at this number: Yes No

May a text message be sent to the cell number above: Yes No

Email _____ May a message be sent to your email: Yes No

Do you want appointment reminders sent to the above email address: Yes No

Do you want text reminders sent to the above cell number 24 hrs. before appt.: Yes No

Education Level: _____ Church you attend: _____

Others in Household:

Name	Age	Sex	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Health Information:

Medications	Condition	Prescribing Doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____

Therapy/Counseling History:

Have you or any person named in this intake package ever been treated by a therapist, counselor, social worker, psychologist, or psychiatrist? Yes No

If yes, please provide names and approximate dates: _____

_____

_____

How were you referred to us? (Google search, Psychology Today, Double T 97.3 Radio, 100.7 The Score Radio, KCBD TV, social media advertisements, counselor referral, friend, etc.): _____

Please briefly state the counseling need you have today: _____

_____

_____

_____

_____

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 Initials _____ _____

DISCLOSURE/CONSENT/POLICY STATEMENTS

The following disclosures are intended to inform you of the policies and the therapeutic practices of Dr. White and Associates (DWA). Please read this information carefully before you sign your consent to therapy. If you have any questions, please ask your therapist/counselor (herein after referred to as therapist).

1. We respect your time and endeavor to always be on time to give you your full 50-minute session. We ask that you give mutual respect for our professional time. A scheduled appointment reserves that time for you. I UNDERSTAND that if I need to cancel my scheduled appointment, I must provide 24 hours' notice prior to the scheduled appointment time. I AGREE to pay the full session fee for missed appointments (no-show without cancellation) regardless the reason, and one half of the session fee for late cancellations (within 24 hours of the scheduled appointment time) regardless the reason. Cancellations can be made by voicemail, email, and through the online scheduling portal at dwatherapy.com.
2. A primary commitment of DWA is to provide you with quality services. However, no therapist can guarantee that their services will be effective for you. This disclosure is intended to convey pertinent information regarding our services, allowing you to make choices based on correct information. All our therapists have earned either Master or Doctoral level degrees. They are licensed by the Texas State Board of Examiners of Marriage and Family Therapists, the Texas State Board of Examiners of Professional Counselors, or the Texas State Board of Social Worker Examiners, or they are working toward licensure under a licensed supervisor. We endeavor to maintain a high level of competence and we adhere to professional, legal, ethical, and moral standards. We seek to integrate cognitive, emotional, behavioral, relational, spiritual, and physical health elements in the therapy process. A variety of techniques and approaches are used. If you have any questions regarding your therapist's training or professional approach, please ask your therapist. Complaints about a licensed professional may be addressed by contacting the Texas State Board of Examiners of Marriage and Family Therapists at https://www.dshs.texas.gov/mft/, the Texas State Board of Examiners of Professional Counselors at https://www.dshs.texas.gov/counselor/, or the Texas State Board of Social Worker Examiners at https://www.dshs.texas.gov/socialwork/.
3. DWA does not provide child care services for parents attending appointments. Children must accompany their parents. I UNDERSTAND that my children are fully my responsibility while on the DWA premises.

4. The fee for services is $65 - $130 per 50-minute session depending on the therapist. I UNDERSTAND that my fees must be paid out of pocket unless my therapist accepts insurance. I AGREE to pay at the time of the session the fee associated with the therapist I have selected.
5. DeDe Long, LPC and Mike Ford, LMFT are providers for some insurance companies. I UNDERSTAND that there is no guarantee that their services are covered by my specific insurance policy. I AGREE to pay the out-of-pocket fee associated with the therapist I have selected if these services are not covered by my specific insurance policy. I UNDERSTAND that it is my responsibility to know what services are covered.
6. I AGREE to pay an additional charge of $25 for checks returned for insufficient funds.
7. I UNDERSTAND that I will be charged for any professional time required of my therapist. I AGREE to pay for my therapist's professional time in a minimum of 15-minute increments for:
    a. communications (phone, email, texts) to/from me, to/from my attorney, or to/from others involved in my case.
    b. file review, research, and preparation for meetings, court, etc.
    c. file preparation for a Release of Information request.
    d. transcription of hand-written notes to typed.
    e. letters written on my behalf.
8. I UNDERSTAND that if my therapist receives a subpoena from my attorney, is verbally requested by my attorney, or is requested by me to schedule my therapist's appearance in court, I will be charged $130 per hour for my therapist's time, at a four-hour minimum charge of $520, plus one hour of preparation time for court, plus additional hours as requested by me, the court, or my attorney. Thus, the minimum fee for court scheduling is $650.
9. I UNDERSTAND that my therapist will not schedule a court appearance without advance payment. I AGREE to pay the fee at the time of scheduling or when a subpoena is served.
10. I UNDERSTAND that this is a non-refundable fee for my therapist's scheduled time if court is cancelled or rescheduled and my therapist is given less than a 3-business day notice of that cancellation (a Monday 9:00 am appearance must be cancelled prior to the preceding Wednesday at 9:00 am). I FURTHER UNDERSTAND that it is MY responsibility to notify my therapist if the scheduled appearance is cancelled.
11. I AGREE to pay for travel time to and from the scheduled appearance at my therapist's hourly rate.
12. I UNDERSTAND that I will be charged for the entire time spent at the court house, not just the time my therapist spends on the proceeding.

 Initials _____ _____

13. I UNDERSTAND that I will be charged as described above even if my therapist appears and is not asked to testify.
14. I AGREE to provide a copy of any and all court documents that may impact me or my family in any way during my time as a client of DWA.
15. I UNDERSTAND that content obtained in the therapy sessions is protected health information (PHI) and electronic protected health information (ePHI), which will be handled professionally and confidentially. This information will be used by your therapist and their supervisor only for your specific treatment needs.
16. I UNDERSTAND that DWA provides full service mental health care through several therapists. These therapists may also treat other members of my family listed in this intake package. I AGREE that my PHI and ePHI may be released to other therapists and other members of my family listed in this intake package as deemed appropriate for treatment by therapists in the DWA organization.
17. I UNDERSTAND that my PHI and ePHI may be released to obtain payment for the services I receive. However, this information will be disclosed either to my responsible party for paying or for bill collection only to the extent necessary to obtain reimbursement for the services provided to me. I AGREE to release my PHI and ePHI as necessary for my therapist to obtain payment.
18. I UNDERSTAND that assessments are PHI/ePHI that require professionally-trained interpretation of the raw data. I UNDERSTAND that DWA will not release assessment raw data.
19. I UNDERSTAND that a signed Release of Information form is required for each person in the record in order to provide copies of a record. If records are requested that include information regarding other parties for which there is not a signed Release of Information, I UNDERSTAND that the information will be redacted at my expense.
20. I UNDERSTAND that there are legal limits regarding PHI and ePHI confidentiality. I AGREE to forfeit confidentiality for any of the following:
    a. If I appear to be under the influence of a substance that may impact my ability to operate a vehicle as I attempt to leave the premises.
    b. If I pose serious physical danger to myself or another person, as determined solely by my therapist's judgement.
    c. If I disclose that I or another person has physically or sexually abused, molested, or neglected a child, an incompetent or disabled person, or an elderly person.
    d. In defense of claims brought by me against my therapist or DWA.
    e. Reporting to relevant agencies such as court and insurance companies as may be ordered by the court system or for third party payment.

 Initials _____ _____

f. If I disclose that I have committed a crime.
g. If my therapist determines that a 911 call is necessary during my session.
h. If any of items 19a – 19g apply, immediate action may be taken.

21. Federal law requires that your PHI and ePHI is managed in specific ways. Our in-house procedures conform to these requirements. However, communication by email, phone, text, and/or other web-based means (remote sessions through WebEx) requires further disclosure. These communication methods by your therapist will comply with laws governing PHI and ePHI. Use of these methods by you poses a low risk of your PHI and ePHI being accessed by a third party. If you choose to communicate with us by/through these methods, you are indicating that you accept this risk. If you desire to not accept this risk, we must maintain our communication at the face-to-face level except for scheduling. I UNDERSTAND these risks and I AGREE to accept the risk when I choose to communicate in these ways.
22. I UNDERSTAND that I will never be asked by DWA to post on social media. However, if I voluntarily post on social media and rating websites, e.g., Google, Facebook, Yellowpages, etc., about my experience with my therapist, I UNDERSTAND that I may reveal myself as a client, which releases PHI and ePHI. If I choose to post on social media, I ACCEPT full responsibility for releasing my PHI and ePHI. Further, by posting on social media, I AGREE that I am authorizing the release of my PHI and ePHI.
23. For mutual convenience, DWA will securely save my credit card information for future use from the card I used to pay today instead of swiping my card at every visit. I AGREE for DWA to process my credit card per the authorization form on the last page of this document.
24. I UNDERSTAND that parental consent is required for mental health treatment of anyone under 18.
□ There are no clients under 18 attending therapy (skip this section, go to 26).
I UNDERSTAND that parental consent must be granted by a legal guardian with the independent right to consent to psychological treatment for clients under the age of 18. I UNDERSTAND that if my independent right to consent to psychological treatment has been altered by any court-ordered arrangements, a copy of the court order must be provided prior to services. I grant my consent for DWA to provide psychological treatment for any child/children named in this intake package based on the following (initial only one applicable option below):
_____ There have never been any divorce, custody, or guardianship orders from a court regarding this child/these children. I am the legal guardian of the minor child/children listed in this intake.
_____ Based on the court order provided today at this first session, I have the independent right to consent to psychological treatment for the minor child/children listed in this intake package. I also

AGREE to provide any future orders that impact my rights in any way.

_____ _____

Legal Guardian Signature Date

25. I UNDERSTAND that audio and/or video recording of a therapy session by myself or my therapist is expressly prohibited without written consent. I AGREE that I will not record my therapy sessions.
26. I UNDERSTAND that video cameras in public areas of the DWA building are for security only.
27. I UNDERSTAND that treatment by more than one therapist at a time can be detrimental to my well-being. No one listed in this intake package has been treated by a therapist within the last 12 months except as noted on page 2 of this intake package. I AGREE to notify my therapist if I or anyone listed in this intake document engage in therapy with another therapist while in therapy with a DWA therapist.

CONSENT TO TREATMENT

I AGREE that I have read and fully understand this document in its entirety, including the disclosures, confidentiality statements, and policies of DWA. I FURTHER AGREE that my signature below and my initials at the bottom of each page indicate my full acceptance of the same in their entirety. I UNDERSTAND that I am giving my informed consent to DWA to be assessed and treated. I employ DWA to provide therapy services. I UNDERSTAND that I will be provided a copy of this intake package at my request.

_____ _____

First Client Signature Date

_____ _____

Second Client Signature Date

_____ _____

Therapist Signature Date

Credit Card Processing Authorization Form

For mutual convenience, DWA will securely save my credit card information for future use instead of swiping my card at every visit. I AGREE that DWA will process my credit card per the terms below:

Name as it appears on the credit card: _____

Relationship with client: _____

Type of Card: □ Visa □ MasterCard □ Discover □ American Express

Card Number: XXXX - XXXX - XXXX - _____

Expiration Date: ____/_____ Security Code: _____

Card holder's billing address associated with the credit card statement:

_____

Street City State Zip

I AUTHORIZE DWA to charge my credit/debit card for all sessions and other fees described in this document, which include appointments, missed appointment fees, late cancel fees, professional time, court appearance scheduled or subpoenaed, out-of-session communications, etc.

I AUTHORIZE DWA to securely save my credit card information for future charges per the above terms.

If any actions taken by me regarding my credit card provider result in a chargeback and/or chargeback fee for any reason, I AGREE to pay any and all penalty fees incurred.

Card Holder Signature authorizing the charges outlined above:

_____ Date: _____

□ I do not authorize saving my credit card information.