Chrismathe Lindsay, Ed.S, LPC, NCC
Holistic Focused Counseling, LLC
2217 North Park Avenue Pearland, TX 77581
Phone: (281) 997-8400 Fax: (281) 997-8408
www.pearlandcounselingcenter.com

OFFICE INFORMATION AND POLICIES

I am pleased that you have selected me as your counselor. This document is designed to inform you of my background and to ensure you understand our professional relationship. I am a Licensed Professional Counselor (LPC) and National Certified Counselor (NCC) with training in working with children, adolescents, adults, families, and groups. I hold a Master's degree in School Counseling from Andrews University and an Education Specialist degree in Mental Health Counseling from Florida Atlantic University. I am an independent private practitioner.

Holistic Focused Counseling, LLC is owned by Chrismathe Lindsay, Ed.S, LPC, NCC. The therapists at Pearland Counseling Center share office space. Each therapist's practice is separate, and each is solely and entirely responsible for any liabilities resulting from that practice.

Goals of Therapy: Counseling is a process whereby the Counselor helps you to help yourself with the problems you are experiencing. Together, you and the Counselor assess your problems and establish goals for counseling. Your Counselor will not make decisions for you, but will facilitate you reaching your goal. Counseling may be beneficial for most people while at the same time there are risks. The risks may include the experience of intense feelings, which may include sadness, anger, fear, guilt, or anxiety. It is important to remember that these feelings may be natural and normal part of the counseling process.

Length of Counseling: Each client will have different issues to address in counseling so there is no set number of sessions you will need to attend. You and your Counselor will decide as you progress how often you should attend counseling. Termination of counseling may happen at any time and may be ended by you or your Counselor. If you are ready to terminate therapy, please allow at least one session so we can have closure.

Dependent Clients: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will require that person to provide legal paperwork stating that this person has this authority and can act for you before we take any action. If a parent or guardian of a child under 18 request services, we need permission to counsel that child. The parent of legal guardian will be asked to sign a form that gives the Counselor permission. It is important that the child trust the Counselor. A parent or legal guardian has the right and responsibility to question and understand the nature and progress of the counseling and the Counselor must use her clinical discretion as to what is appropriate to disclosure. While the Counselor may not tell you specific information your child provides, the Counselor will discuss your child's participation and progress in treatment.

Couples Therapy: If you are coming for couple's counseling, the couple is considered to be the client and I will meet with both of you. I utilize the Gottman Method Couples Therapy approach which is based on years of scientific research by Dr. John Gottman. Our work together will include helping you to learn skills that will enhance the friendship and intimacy in your relationship and manage conflict.

My work with couples begins with an assessment that has three parts. At the first conjoint session, we will discuss your areas of concern, the history of your relationship and your goals for treatment. The first conjoint session can last between 80-90 minutes. After the conjoint session, each individual person will fill out a confidential online assessment that will help me understand your relationship further. The assessment was created by the Gottman Institute. There is a small cost for taking and scoring the assessment, which is not covered by insurance. The online assessment is a therapeutic tool I use for creating the treatment plan needed to best help you. It will not be part of the clinical record and is not available to either party because it is meant to be read and interpreted by a trained professional. After you have completed the online assessment, I will meet with you each individually to learn about your perspective, family-of-origin, and personal history. The individual session will be a 45-50 minutes session which is the standard time for a couple's session. During the third session, I will review the assessment findings and recommendations with the couple and together arrive at a mutually agreed upon goal to begin our work together.

Once I begin working with the couple, I do not see each of you individually after the assessment period. Should the couple decide they want to terminate couples counseling for any reason after starting and one of the couple want to proceed with individual counseling, I can only see one of you if both parties agree and will provide referral to another counselor should the other party wish to also participate in individual counseling. Also, once couples counseling is terminated it cannot be resume with me in the future if one of them is receiving individual counseling services.

Appointments and Messages: Calls are recorded by a confidential voice mail system and are returned as soon as possible. To facilitate this, the caller needs to leave a daytime/evening phone, cell, or pager number along with current concerns. In the event of an emergency please call 9-1-1. The counseling service is by appointment only. The length of the counseling session is usually **45-50 minutes,** or what is known as a clinical hour. Because an appointment is reserved for you, it is required that you let us know **by 1:00 pm the day prior to your appointment** if you must cancel or reschedule your appointment. I am very committed to keeping appointments with you. If, due to an emergency, I must delay or cancel your appointment, I will make every effort to contact you to re-schedule.

***You are financially responsible for the session missed unless you have given the proper notice.**

***No show or No call is a fee of $50.00.**

Fees: The standard self-pay fee for a psychotherapy session is outline in the payment contract for services along with services provided outside the scope of the therapy sessions. This will be provided to you during the initial session. The fee for services are due prior to providing services.

Filing w/Insurance: If you have a health insurance policy, it will usually provide some coverage for mental health treatment. My office can assist you by filling your insurance or providing you with the form in helping you get directly reimburse for the benefits to which you may qualify for; however, you are responsible for the full payment of my fees. It is very important that you know exactly what mental health services your insurance policy covers. If you have any questions about the coverage, call your plan administrator.

Also, be aware that it may be required that I provide your insurance company with a diagnostic code and information relevant to the services that I provide to you. I will make every effort to release the minimum information about you that is necessary for their purposes.

Limits of Confidentiality and Client's Right: Clients are assured that confidentiality is protected by ethical practice and the laws of the State of Texas. There are few exceptions to confidentiality that are legally mandated. In general terms they include:

- A requirement to notify relevant others if a client has any intentions to harm another person or themselves.
- A requirement to report any incidence of suspected child, elderly or disabled person abuse or neglect.

Your signature on this Agreement provides consent for the following activities:

- To file insurance or work with a managed care company, information regarding your treatment, diagnosis, prognosis and the specific issue for which you have come to treatment are available to the insurance or managed care company. We make every effort to release only the minimum information about you that is necessary for the purpose requested. Once this information is turned over to the insurance, managed care company, or requesting entity, the counselor has no control over how the information is to be used. *Please see "Notice of Privacy Practices" brief version for additional information located in your introduction packet. A long version of the Notice of Privacy Practices is available upon request and is also posted in the waiting room.
- Consultation with other health professionals about your case to provide optimal care. During consultation, I make every effort to avoid revealing the identity of clients. The other professionals are also legally bound to keep information discussed confidential. I will tell you about these consultations if I feel it is important to our work. I will also note all consultations in your record.
- Processing by administrative staff. In most cases, I need to share protected information with staff for administrative purposes, such as scheduling and/or billing.
- If a client files a compliant or lawsuit against me, I will disclosure relevant information regarding that client to address the complaint.
- While my present or potential clients might conduct online searchers about my practice and/or me, I do not search my clients on Google, YouTube, Facebook, or other search engines or online social networking sites. If

clients ask me to conduct such search or review their web sites or profile, the benefits and risks will be discussed during the counseling session before I will consider it.

- I do not accept friend requests from current or former clients on my psychotherapy related profile or social networking sites due to the fact that these can compromise client's confidentiality and privacy. For the same reason, I request that clients do not communicate with me by any interactive or social networking websites.
- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and therapy, such information is protected by law. I cannot provide any information without your written authorization, or court order.

Transfer Plan for Incapacitation or Death: In the unlikely event that I am unable to provide ongoing services Shawn Quintanilla DPC, LPC, LMFT will provide those services or will refer you to the appropriate resources. Shawn Quintanilla DPC, LPC, LMFT may be contacted at 281-997-8400. Her role as custodian includes:

- Access information. I will provide the custodian location(s), keys, password, access codes and other information necessary or a protocol to obtain this information in order to execute the transfer plan.
- Notify you of my inability to practice. The custodian will send a letter to you notifying you of my inability to practice. The custodian will offer to provide ongoing counseling services (if clinically appropriate) or provide referrals to the most appropriate service provider.
- Possession of clinical records. The custodian will take possession/responsibility of the clinical records and inform you on procedures to access your clinical records.
- Request for information. The custodian will respond to a request for information in concert with state laws, HIPPAA guidelines, and code of ethics.
- Maintaining and destruction of clinical records. The custodian will maintain clinical records (post treatment) for adults seven years or five years past age of majority for minors.

Records Request: We make every effort to keep your mental health records secure per HIPAA (Health Insurance Portability and Accountability Act) and the Texas Health and Safety Code regulations.

To request a copy of your (the clients) mental health records:

1) Request a copy of your mental health records/documents in writing. If you mail your request, address the request to your therapist at 2217 N. Park Avenue, Pearland, TX 77581. Please print and sign your name on the request.
2) Please be aware your request for a copy of your records or a copy of documents from your records can be denied.
3) Your therapist has up to 15 days after receipt of your request to provide the requested documents or provide a denial of the request.
4) There may be a fee charged for the requested mental health records/documents.

Complaint Process: An individual who wishes to file a complaint against a Licensed Professional Counselor may write to:

Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369
1-800-942-5540

I look forward to being of service to you and encourage you to participate actively and to stay informed about your counseling process.

THIS PAGE INTENTIONALLY LEFT BLANK

Upon complete review of all documents in this packet, pages 1-12, your therapist will provide an Acknowledgement and Consent form to be signed by you (the client) and your therapist during the initial session.

I (the client) understand that pages 1-12 (Excluding Signature Page, page 4) of this packet are available to me anytime online at www.pearlandcounselingcenter.com or by request. This request can be made in person at Pearland Counseling Center, 2217 North Park Avenue, Pearland, Texas 77581.

I (the client) understand that my signature is required on the Acknowledgement and Consent form before services can be provided. I (the client) understand that **if I choose NOT to sign the Acknowledgement and Consent form counseling services will NOT be provided.**

IMPORTANT: It is required the Acknowledgement and Consent form is signed by you (the client) and witnessed prior to the start of counseling services.

CLIENT REGISTRATION PAGE

TODAY'S DATE: _____

Patient Name: _____ DOB: __ __ - __ __ - __ __ __ __ Age: ___ Gender: ___

Marital Status: **SINGLE MARRIED DIVORCED WIDOWED** SS#: __ __ __ - __ __ - __ __ __ __ DL#: __ __ __ __ __ __ __ __

Address: _____ APT#:_____

City: _____ State: _____ Zip: _____

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

May we contact your home #? _____ May we contact your work #? _____ May we contact your cell #? _____

May we leave a message? Y N May we leave a message? Y N May we leave a message? Y N

E-Mail Address: _____

Employer: _____ Occupation: _____

Emergency Contact

Name: _____ Relationship: _____

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

Name of person responsible for client: _____ Relationship: _____

INSURANCE INFORMATION

Name of Insured person: _____ Relationship: _____

Insured SS#: __ __ __ - __ __ - __ __ __ __ Insured DOB: __ __ - __ __ - __ __ __ __ Gender: _____

Insured Employer: _____ Employer Phone #: __ __ __ - __ __ __ - __ __ __ __

Name of Insurance: _____ Ins. Phone #: __ __ __ - __ __ __ - __ __ __ __

ID or Policy #: _____ Group #: _____

ADDRESS AND CONTACT INFORMATION OF INSURED PERSON, IF NOT THE SAME AS CLIENT

Address: _____ APT#:_____

City: _____ State: _____ Zip: _____

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

MEDICAL HISTORY

Reason for seeking Counseling: _____

_____

Other physicians treating you: _____ Phone #: __ __ __ - __ __ __ - __ __ __ __

Other physicians treating you: _____ Phone #: __ __ __ - __ __ __ - __ __ __ __

Other physicians treating you: _____ Phone #: __ __ __ - __ __ __ - __ __ __ __

Current physical problems (describe): _____

_____

Current Medications: _____

_____

NOTICE OF PRIVACY PRACTICES – BRIEF VERSION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required NPP which is available upon your request and contains more information regarding your protected health information. Please talk to your Privacy Officer (see the end of this pamphlet) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities which are called, in the law, health care **operations.** After you have read this NPP we will ask you to sign a **Consent Form** to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this.

Of course, we will keep your health information private but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires to do so.

4. For Workers Compensation and similar benefit programs.

There are some other situations like these, but which don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records. *You can even get a copy of these records, but we may charge you. Contact your Privacy Officer to arrange how to see your records. See below.

4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to your Privacy Officer. You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy of the NPP from your Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with your Privacy Officer Chrismathe Lindsay, Ed.S, LPC, NCC at 2217 North Park Avenue, Pearland, TX 77581. All complaints to our Privacy Officer must be in writing. You can also file a complaint with the Secretary of the Department of Health and Human Services Office for Civil Rights at 200 Independence Ave., S.W. Washington, D.C. 20201, or by calling 1-877-696-6775 or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact your Privacy Officer who is Chrismathe Lindsay, Ed.S, LPC, NCC and can be reached by phone at (281) 997-8400.

The effective date of this notice is February 01, 2017.

Acknowledgement of Receipt of Notice of Privacy Practice

I, _____, have read and understand this document. I recognize that I have the opportunity now and in the future to discuss any question I may have with my counselor. I agree to the practices and policies delineated herein and have received a copy of this Office's Notice of Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

It is your right to refuse to sign this document

For Office Use Only:

The reason that a standard acknowledgment (such as the above) of the receipt of the Notice of Privacy Practices was not obtained:

_____ Patient refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented this office from obtaining it.

_____ Others: _____

Email and Texting Consent

HIPAA regulations and my professional Code of Ethics both require that I keep your Protected Health Information private and secure, and indeed I want to do so. Email is a very convenient way to handle administrative issues like scheduling or receipt requests, but email is not 100% secure. Some of the potential risks you might encounter if we email include:

- Misdelivery of email to an incorrectly typed address.
- Email accounts can be 'hacked,' giving a 3rd party access to email content and addresses.
- Email providers (i.e., Gmail, Comcast, and Yahoo) keep a copy of each email on their servers, where it might be accessible to employees, etc.

For these reasons, I will not use email to discuss clinical issues (i.e., the important things we talk about in session.)

If you are comfortable doing so, I am happy to use email to handle small administrative matters like scheduling and billing. This will only be utilized if the Office Staff is unavailable to assist you with these matters.

The Office Staff will handle all scheduling, billing and other office matters by phone only. Email and text will not be used as a form of communication. If this policy changes, you will be notified at the time of change and be provided with an updated consent to review and sign.

If you are not comfortable with these risks, we can handle administrative issues via phone calls.

I do not text clients appointment confirmations.

Please indicate your preference about email below and sign. (CIRCLE ONE)

I DO or DO NOT consent to use email for administrative matters.

If given, consent will expire 2 years after our last appointment. This means that I will not initiate contact via email, although you are always still welcome to email me, and I can reply briefly if you do.

Printed Name: _____

Signature: _____ Date: _____

POLICY FOR NO SHOW/LATE CANCEL AND OUTSTANDING BALANCE DUE

We are very committed to serving our clients and strive to accommodate all of our clients by making appointments available as soon as possible.

When an appointment is reserved for you, we require that the appointment be cancelled by **1:00 pm the day prior to the appointment.** We understand that emergencies happen, and we will be happy to work with you in those situations. If you have any questions, please feel free to speak with our office manager.

****

I understand that I will be responsible for a **missed appointment fee of $50.00** and that my credit card will be charged if I am unable to provide the proper notice that I will not keep my scheduled appointment. Note: This policy may also apply to sessions provided by Employee Assistance Programs (EAP).

I also understand that I will be responsible for any outstanding balance for services rendered and that my credit card will be charged to pay for the outstanding balance.

If you choose to provide your flexible spending account information, an additional credit or debit card number is required as the situation may occur that your flex account holds insufficient funds or its balance has become depleted.

We accept the following debit/credit cards: Visa, Discover, American Express and MasterCard.

FOR FLEX CARD:

Name As Appears On Card: _____

Credit Card Number: ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____

Expiration Date:_____

FOR CREDIT/DEBIT CARD:

Name As Appears On Card: _____

Credit Card Number: ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____

Expiration Date:_____

I have read, understand and agree to the Policy above and give my permission for my card to be charged if a violation occurs.

Print Name: _____

Signature: _____ Date: _____

I _____ (CREDIT CARD HOLDER NAME) understand that by providing my Credit Card information I am consenting to being financially responsible for _____ (CLIENT NAME) regarding any violation of the Policy stated above.

Print Name: _____

Signature: _____ Date: _____

You may revoke this consent at any point, by submitting a request in writing which MUST include:
Date of request, client's name, your name, signature, copy of your current Driver's License, and an explanation of the information to be removed. If you are mailing your request, please keep in mind there could be charges to your card until your request is received by our office.

OFFICE USE ONLY: DATE OF REVOKE REQUEST _____ DATE REQUEST REC'D (EFF. DATE OF REVOKE) _____

SOCIAL MEDIA

Social media is used for personal use only and should not be used in professional relationships. In order to respect the boundaries of both the clients and the staff, including maintaining confidentiality, there can be no affiliation on these websites.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client's Initials: _____

INSURANCE – ASSIGNMENT AND RELEASE

I the undersigned certify that I (and/or my dependents) have insurance coverage with _____ and that I assign directly to Chrismathe Lindsay, Ed.S, LPC, NCC all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize Chrismathe Lindsay, Ed.S, LPC, NCC to release any information necessary to secure payment of benefits. I authorize this signature on all insurance submissions.

Client's Initials: _____

POLICY FOR PROVIDING NEW INSURANCE INFORMATION

Our clients are very important to us and our main goal is make their time here as pleasant and smooth as possible. It is pertinent that we receive any updated information prior to your scheduled appointment so that we are able to avoid any discrepancies with your insurance coverage.

If/when you acquire new insurance, we require a 48 HOUR NOTICE prior to your scheduled appointment. If you do not provide your updated insurance information within the 48 hour timeframe you will be subject to a fee. The fee will be based on the contracted rate of your insurance company.

I understand that I will be responsible for any fees and/or balances owed on my account if I do not provide my new insurance information within the required time period. This includes claims that are denied.

Client's Initials: _____

Print Name: _____

Signature: _____ Date: _____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** _____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____

In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality overall?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	