# Demographic Information:

Client Name

Parent/Guardian Name (if applicable)

Address

Address

🗆Home 🗆Cell 🗆Work

Phone

🗆Home 🗆Cell 🗆Work

Alternate Number

Email Address

Date of Birth/Age

**Correspondence:**

In some situations, I might need to contact you to confirm, reschedule or cancel an appointment or to obtain payment for a missed session. Please indicate which way I can contact you in the future, if needed.

🗆It is ok to leave messages at the following numbers: 🗆Home 🗆Cell 🗆Work

🗆Please do not leave messages at any above number.

🗆It is ok to correspond through mail at the above address.

🗆It is ok to correspond using the email address above.

# Informed Consent/Rights/Responsibilities

## Overview:

Margery Boucher, MA, MS, LPC is an independent provider, and has no relationship with any managed care or insurance company. She does not accept third party reimbursement and are therefore under no obligation to such entities with regard to client services or information. Her psychotherapy services are offered to individual adolescents and adults, couples, families, and children, usually on a once‐per‐week basis.

## Goals, Risks & Benefits

There is always a risk of emotional side effects from counseling. *Sometimes symptoms worsen before they get better*. Often counseling brings up painful emotions. Our goal is to confront issues and emotions together and to work through them over time.

Some of the more common risks that you should be aware of are:

• Long‐lasting psychological change often requires a significant investment of time, often longer than a client’s initial perception.

• Clients often experience deterioration in emotional and psychological stability at different times during the therapeutic process. This often occurs during the beginning stages of therapy, but may occur at any point, often brought on by an awareness of previously unconscious, emotionally‐laden material.

• Relationships are often affected as a result of therapy. Significant relationships will often experience varying degrees of tension. This is often the most prevalent within family relationships, but may extend beyond into one’s social and professional life.

## Appointment Scheduling/Attendance/Cancellation:

Regular psychotherapy promotes faster healing and progress, so it important that you attend your scheduled therapy session consistently. Margery’s policies are outlined below.

• If I cannot attend a session, I agree to notify my therapist at least 24 hours in advance.

• I understand that I will be charged for any session cancelled with less than 24‐hours notice.

• Your therapist reserves the right to transfer/terminate services at any time, for any reason they consider therapeutically appropriate.

There are policies/procedures in place allowing for exceptions to the above policy. Please discuss any concerns or special circumstances you may have. Please note that exceptions to the above attendance policy do not necessarily relieve responsibility for payment of those sessions.

## Fee/Payment:

Your fee for service will be determined by your therapist. With regard to payment for services:

• Payment is due at the time of service delivery.

• I agree to pay a $20.00 service charge for each check that is returned to Margery Boucher.

**The client is required to pay for any missed sessions unless he/she calls 24 hours in advance to cancel the appointment. An exception may be made if your therapist deems the situation an emergency. Session Cancelation Fee: amount equivalent to missed session type.**

⬩All fees incurred for lost time/wages because of court hearings, subpoenas served, or other legal matters regarding client(s) business will be paid in a timely manner by the client(s) signing below. Wages to be paid will consist of $300/hr minimum.

⬩Keep your receipts in a safe place for insurance/tax purposes. Clients sometimes ask for additional copies of receipts. While we are happy to be of service to you, this is a time consuming process for our administrative staff.

⬩Therefore, like other organizations, we charge a **$25** fee for this service, to cover the cost of labor, copying, and postage or fax.

INSURANCE MAY REIMBURSE ALL OR PART OF COUNSELING FEES. Margery Boucher, MA, MS, LPC DOES NOT FILE INSURANCE; HOWEVER, DOCUMENTATION IS PROVIDED SHOULD THE CLIENT CHOOSE TO FILE WITH HIS INSURANCE PROVIDER.

## Confidentiality:

I understand that Texas state law requires that information provided to mental health practitioners remain confidential, and Margery Boucher makes every effort to ensure confidentiality is maintained with respect to all aspects of your treatment. As a client, you agree to the following exceptions to confidentiality, in which case information may be disclosed to the appropriate authorities/agencies/individuals:

• If your therapist has reason to believe that you may harm yourself or others.

• If your therapist has reason to believe that you are involved in or have knowledge of abuse or neglect of a child; or abuse, neglect, or exploitation of a person who is elderly or has a disability.

• Ordered disclosure by state or federal courts.

In addition, Margery Boucher requires disclosure of information in the following circumstances:

• A signed release form granting permission to designated third parties to receive information (as needed).

• In the case of minors, parents or legal guardians have access to their child’s records, unless emancipated.

## Emergencies:

During office hours (9-6/M-Sat), the client can contact the counselor. If the client is unable to reach his counselor in a timely manner, client should contact his physician, a local emergency room or 911 when necessary and appropriate. It is the client’s responsibility to seek the appropriate resources in emergency situations.

The client may also contact the Mobile Crisis unit 24-hours a day: 866-260-8000

## Complaints, you may contact:

• Texas State Board of Examiners of Professional Counselors (512) 834‐6658

• Mailing address for all: 1100 West 49th Street, Austin, TX 78756

By signing below, I acknowledge that I have read, understand, and agree with the aforementioned information.

Client or Guardian Printed Name:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_

Counselor Printed Name:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_

# Intake Questionnaire

Client Name Date

Guardian Name (if applicable)

What, if any medications are you/your child on?

|  |  |  |
| --- | --- | --- |
| * **Abilify** * **Adderall** * **Adderall XR** * **Buproprion SR** * **Celexa** * **Clonadine** * **Concerta** * **DaytranaTransdermal Patch** | * **Depakote** * **Depakote ER** * **Impirimine** * **Lexapro** * **Methylin** * **Prozac** * **Risperdal** * **Ritalin** * **Ritalin LA** | * **Seroquel** * **Strattera** * **Trileptal** * **Wellbutrin** * **Wellbutrin XL** * **Zoloft** * **Other**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * **NONE** |

Are medications being taken as prescribed? 🞎 Yes 🞎 No

Prescribing physician’s name/number:

**Please complete a Release of Information form**.

Please describe any side-effects from medications:

List Previous Medications and reason(s) discontinued.

What, if any, allergies does you/your child have to medications?

Date of last physical Primary Care Physician Name:

Outcome/Findings:

Who referred you for services?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎Family history of mental health disorders? If so, who?

🞎Eating problems:

🞎Sleep Problems:

🞎Substance Use: 🞎Caffeine 🞎Tobacco 🞎Alcohol 🞎Marijuana 🞎Cocaine 🞎Cheese 🞎Ecstasy 🞎IV Drugs

🞎Family history of substance use? If so, who?

🞎Hospitalizations

🞎Surgeries

🞎Other Medical Problems

🞎Abuse History:

🞎Physical

🞎Emotional

🞎Sexual

🞎Current/Pending Abuse Issues:

🞎Head Injury:

🞎Seizure Disorder: Date Diagnosed Treatment:

🞎EEG done/date Any loss of consciousness?

🞎Developmental Delays:

🞎Educational Concerns/Learning Disabilities:

Emergency Contact:

Name/Relationship:

Phone Number:

**In the case of emergency, I authorize the aforementioned person (s) to be contacted on my behalf.**

Client/Guardian Signature Date

**Additional Information:**

**What are 3 goals you have for seeking counseling:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What are your top 3 coping skills (healthy or unhealthy):**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle each term that describes your current feelings/concerns:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Angry | confused | optimistic | indifferent | hopeful |
| hopeless | unhappy | jealous | anxious | lonely |
| suicidal | hopeful | sad | outgoing | hurt |
| irritable | numb | loss of faith | marital stress | cheerful |
| overeating | depressed | bereaved | loss of appetite | drug use |
| happy | guilty | worried | alcohol use | fearful |
| grieving | poor sleep | habits | recent move | fearful |
| resentful | ambitious | inadequate | apathetic | poor sex drive |
| energetic | dangerous | distrustful | work stress | Other: |

**Please circle your level of agreement with each of these statements using the following scale:**

0 = Not at all 1 = Very Little 2 = Somewhat 3 = Very Much

I need to talk about things that happened to me in my growing up years. 0 1 2 3

I do not need counseling; I am here because someone insisted that I come. 0 1 2 3

I seem to keep making the same mistakes over, even though I try not to. 0 1 2 3

I am wondering if I need medications to help with the way I feel. 0 1 2 3

I sense that God is part of what I am going through. 0 1 2 3

I need to discuss my problem with alcohol, drugs or other painful behavior. 0 1 2 3

**Substance Abuse**

Do you drink alcoholic beverages? (Y or N)

If yes, then how often: Every day? \_\_\_\_\_\_\_ Occasionally? \_\_\_\_\_\_\_ Never? \_\_\_\_\_\_\_

Do your friends drink alcohol? (Y or N)

Do you smoke or use tobacco in another form? (Y or N)

If yes, then how often: Every day? \_\_\_\_\_\_\_ Occasionally? \_\_\_\_\_\_\_ Never? \_\_\_\_\_\_\_

Do your friends smoke? (Y or N)

Do you use any other drugs? (Y or N)

If yes, then how often: Every day? \_\_\_\_\_\_\_ Occasionally? \_\_\_\_\_\_\_ Never? \_\_\_\_\_\_\_

Have you ever been verbally, physically, emotionally, or sexually abused? (Y or N) Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attempted suicide? (Y or N) Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Limits to Confidentiality

Client information is considered confidential communication (whether in person, on the phone, in writing, or otherwise communicated) and is not to be shared with any other entity (person or organization) without specific written permission from the client or guardian, expect under the following conditions:

1. Client threatens harm to self.
2. Client threatens the harm of another person(s): including, but not limited to murder, assault, and any other physical harm. This information will be provided to law enforcement and/or probation officer.
3. In the case of physical, sexual, psychological and/or emotional abuse to a child, elderly or disabled person, the clinician can make a report to the appropriate authorities. Situations could include the following, but are not limited to these specifically:
   1. If the client is a minor (under age 18) and reports current or history of abuse or if clinician suspects abuse to child, including but not limited to physical, sexual, emotional and/or psychological abuse.
   2. If the client is an adult and reports or clinician suspects the aforementioned abuse is occurring within the home to a child, elderly, or disabled person, even though that individual is not the clinician’s client.
4. The client’s behaviors are in direct violation of his/her probation.

State law mandates that mental health professionals are mandated to report the aforementioned situations to the appropriate authorities.

TAC-Title 25, Part II-CH403, Subchapter K-403.295 prohibits the disclosure of confidential information without expressed written consent of the client and/or legal guardian.

Signing below indicates that you have read, understood, and agree with the limits to confidentiality:

Printed Name of Client

Client/Parent/Guardian Signature Date

Clinician Signature Date

**PRIVACY POLICY (HIPAA)—CLIENT COPY**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE READ IT CAREFULLY.**

Margery Boucher, LPCS understands that your medical information and your health are personal. I am committed to protecting your medical information. I need this medical information to provide you with quality care and to comply with certain legal requirements. This Notice of Privacy Practices applies to your medical information generated and/or maintained by Margery Boucher, LPC.

This Notice will tell you about the ways in which we may use and disclose your medical information. We also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

Margery Boucher is required by law to:

1. Make certain that medical information that identifies you is kept private
2. Make certain that you are given notice of our legal duties and privacy practices with respect to your medical information
3. Make certain that Margery Boucher follows the terms of the Notice of Privacy Practices that is currently in effect

The following describes different ways we use and disclose your medical information. If you are receiving services for the evaluation or treatment of substance abuse or Human Immunodeficiency Virus (HIV) conditions, specific rules apply to the use and disclosure of information related to those services. Please refer to the section entitled Substance Abuse Health Information and HIV Information for those rules.

1. **For Treatment.** We may use your medical information to provide you with behavioral health treatment or services. We may disclose your medical information to psychiatrists, your primary care physician, nurses, therapists, case managers, or other behavioral health professionals who are involved in your care. For example, a psychiatrist treating you may need to know if you have allergies to certain psychotropic medications. The psychiatrist may need to contact your primary are physician to obtain that information. Margery Boucher may also share your medical information to arrange services you may need. Different departments of your provider network may also share your medical information in order to coordinate the services you need, such as medications, therapy, or case management. If you are in jail, Margery Boucher may share your medical information with necessary medical personnel to coordinate your ongoing care.

1. **For Payment.** We may use and disclose your medical information so that the treatment and services you receive may be billed and payment may be collected from appropriate payers, such as an insurance company or a third party. For example, we may need to give your network provider medical information about treatment you received at the hospital so the hospital can receive payment. Your network provider may share your medical information with your insurance company or a third party payer to check that you qualify for services, or to obtain approval for the services requested.
2. **For Health Care Operations.** We may use and disclose your medical information for business activities. These uses and disclosures are necessary for administrative functioning and to ensure our members receive quality care. For example, we may use your medical information to review a network; provider’s services and to evaluate their performance in caring for you. We may combine medical information about many members to decide what additional services Margery Boucher should offer, what services are needed, and whether certain new treatments are effective. We may use and disclose your medical information to access Margery Boucher’s compliance with the Texas Department of Health Services, or the Joint Commission on Accreditation of Healthcare standards. For example, this disclosure may be required to evaluate the quality of services we provide or to resolve a specific treatment issue you have raised.
3. **Individuals Involved in Your Care.** We may release your medical information to a family member actively involved in your care and treatment as allowed under Texas state law and in accordance with Margery Boucher’s policies and procedures. This information is limited and **will not be disclosed without first obtaining your written authorization**.
4. **Substance Abuse Health Information.** All medical information regarding substance abuse is kept strictly confidential and released only in conformance with the requirements of federal law (42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3) and regulation (42 C.F.R. part 2). Disclosure of any medical information referencing alcohol or substance abuse may only be made with your written authorization. A general authorization for the release of medical or other information is not sufficient for this purpose.
5. **HIV Information.** All medical information regarding HIV is kept strictly confidential and released only in conformance with the requirements of state law (Subtitle D, Title 2, Health and Safety Code, Chapter 85, section 85.115). Disclosure of any medical information referencing HIV status may only be made with your written authorization. A general authorization for the release of medical or other information is not sufficient for this purpose.
6. **Special Circumstances.** Federal and state laws allow or require Margery Boucher to disclose your medical information in certain special circumstances that include, but are not limited to the situations described below.
   1. **Public Health (Health and Safety for you and / or others).** We may disclose your medical information for public health activities. We may use and disclose your medical information to a public health authority, when necessary, to prevent a serious threat to your health and safety or the health and safety of the public or another person. These activities generally include the following:
      * To prevent or control disease , injury or disability
      * To report births or deaths
      * To report child abuse or neglect
      * To report reactions to medications
      * To notify people of recalls regarding medications they may be using
      * To notify a person who may have been exposed to a disease or may be a risk for contracting a disease
      * To avert a serious threat to the health or safety of a person or the public
      * To notify the appropriate government authority if we believe a member has been the victim of abuse, neglect or domestic violence. We will make this disclosure when required or authorized by law.
   2. **Research**. Under certain limited circumstances, we may use and disclose your medical information for research purposes. For example, a research project may involve the care and recovery of all members who receive one medication for the same condition. All research projects are subject to a special approval process. We will obtain your written authorization if the researcher will use or disclose your medical information.
   3. **Health Oversight Activities**. We may disclose your medical information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the behavioral health care system, government programs, and compliance with civil rights laws.
   4. **Lawsuits and Disputes**. If you are involved in a lawsuit or legal action, we may disclose your medical information in response to a valid court or administrative order, a valid subpoena, a discovery request, or other lawful process that complies with state law and Providence of Texas policies and procedures.
   5. **Law Enforcement**. We may not release your medical information to a law enforcement official except in response to a valid court order, subpoena, warrant, summons, or similar lawful process that complies with state law and Margery Boucher’s procedures.
   6. **Coroners, Medical Examiners and Funeral Directors**. We may release your medical information to a coroner or medical examiner. This may be necessary for identification or to determine a cause of death. We may also release your medical information to funeral directors as necessary to carry out their duties.
   7. **National Security and Intelligence Activities**. We may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
   8. **Protective Services for the President and Others.** We may disclose your medical information to authorized federal officials so they may provide protection to the President or other authorized persons.
   9. **As Required By Law.** We may disclose your medical information when required to do so by federal, state, or local law.

* **Right to Access.** You have the right to inspect and copy medical information that ay be used to make decisions about your care. To inspect and copy your medical information contact Margery Boucher. If you request a copy of the information, you may receive one copy each at no cost. For any additional copies during the same year, you may be charged a fee for the costs of copying, mailing, or other supplies associated with your request. Your request to inspect and copy your medical information may be denied in certain limited circumstances. If you are denied access to all, or any part, of your medical information, you may request that the denial be reviewed. Information regarding how to initiate the review process will be provided in writing at the time of any denial of access to your medical information.
* **Right to Amend.** If you feel that your medical information is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as your medical information is kept by Margery Boucher. To request an amendment, your request must be made in writing and submitted to Margery Boucher. You must provide a reason that supports your request. We may deny your request if you ask us to amend information that:
  1. was not created by us, unless the person or entity that created the information is no longer available to make the amendment
  2. is not part of the medical information kept by or for Providence of Texas
  3. is not part of the medical information which you would be permitted to inspect or copy; or
  4. is accurate and complete.
* **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures of your medical information to others outside of Margery Boucher’s office. The accounting does not include information disclosed as a part of treatment, payment, or health care operations. The accounting does not include disclosures that were authorized by you in writing. To request this accounting, you must submit your request in writing to Margery Boucher. Your request must state a period of time for the accounting that may not be longer than six years.
* **Right to Request Restrictions.** You have the right to request a restriction on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree, we will comply with your request, unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to Margery Boucher’s office. In your request, you must tell us what information you want to restrict, and to whom you want the restriction to apply.
* **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location if you believe that you will be otherwise endangered. For example, you can ask that we only contact at a certain telephone number or address. To request confidential communications, you must make your request in writing to Margery Boucher. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
* **Right to Paper Copy of This Notice.** You have the right to a paper copy of this privacy notice. You may ask us to give you a copy of this privacy notice at any time by requesting it from Margery Boucher.

Margery Boucher reserves the right to change this notice. Margery Boucher reserves the right to make the revised notice effective for your medical information that Margery Boucher already have about you, as well as any information we will receive following the revision. Margery Boucher will post a copy of the current notice. The notice will contain the effective date at the bottom of each page. Margery Boucher will make you aware of any revisions by posting the revised notice in all the above locations.

Other uses and disclosures of your medical information not covered by this notice will be made only with your written authorization. If you provide us with written authorization to use or disclose your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, Margery Boucher will no longer use or disclose your medical information for the reasons covered by the authorization.

I hereby acknowledge that I read and understand my privacy rights, the aforementioned HIPPA information, and was offered a copy of the above information.

Printed Name of Client

Client/Parent/Guardian Signature Date

Clinician Signature Date

# Release of Information Disclosure Form

By signing this form, I authorize the disclosure of information for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

to the following person/organization: (client’s name)

Name/Organization

Address

Phone Number Fax Number

This form also allows the aforementioned person/organization to provide Margery Boucher, MA, MS, LPC with information to assist in the treatment of the client.

|  |  |
| --- | --- |
| *Margery Boucher, MA, MS, LPCS*  *8215 Westchester Dr. Ste. 240*  *Dallas, TX 75225* | *Phone: 214-982-0026*  *Fax: 866-425-9538* |

A. Unless otherwise specified below, any and all information regarding this client can be disclosed to assist in the treatment of the client. This can include, but is not limited to diagnosis, treatment, prognosis, chemical dependency, and/or medical knowledge including HIV health information.

Please indicate if you **do not** want specific information disclosed:

B. The intended purpose of the release of information is for **continuity of care**. If other purpose, explain:

C. This authorization will expire upon **conclusion of treatment**, unless otherwise specified below and/or revoked by signing and dating below:

D. Clinician Margery Boucher **cannot guarantee** that the individual/organization contacted through this release of information will not disclose some or all of the information provided. The said individual/organization might not be bound by the same legal obligation to confidentiality as the treating clinician.

By signing below, I indicate that **I have read, understand, and agree** with the aforementioned information. I was given the opportunity to ask questions and was not forced or coerced into singing this document.

Printed Name of Client

Client/Parent/Guardian Signature Date

Clinician Signature Date

Margery D.E. Boucher, MS, MS, LPC-S

3110 Webb Ave. Ste 160

Dallas, TX 75205

LIC #68192

EIN #47-2163289

NPI #1487686184

**Credit Card Authorization**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Margery Boucher, MA, MS, LPC-S permission to charge the following credit card:

Name on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of card: Visa MC Discover AmEx Other: \_\_\_\_\_\_\_\_\_\_\_

Card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CVV/Security code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the above card to be charged for the following purpose(s):

Intake Individual Therapy

Family Therapy Couples Therapy

Concierge Services Group Therapy

Supplies Court/Legal

By signing below, I acknowledge that this release is valid when signed and that I may revoke consent at any time.

Printed Name of Client

Client/Parent/Guardian Signature Date

Clinician Signature Date