Life Matters Counseling, PLLC

1100 Halle Park Circle, Suite 101, Collierville, TN 38017-7178
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Information for New Clients

Thank you for giving us the opportunity to serve your psychological and counseling needs. As trained, experienced therapists, we continuously strive to provide a safe and welcoming environment in which to address your concerns and help you develop a game plan. The following information will help you learn more about Life Matters Counseling, PLLC, and the services we provide.

Each person who will be attending sessions should read these forms and documents.

You will need to print and sign some of these forms, and bring them with you to the first appointment. For example, if your spouse, partner, parent, or guardian will be attending appointments with you, then each person should fill out these forms and bring them to the first session.

- ❑ **READ** the **Life Matters Counseling, PLLC Practice Policies** form. *This provides important information about our services, policies, and procedures.*
- ❑ **READ** the **Patient Notification of Privacy Rights** form. *This form describes how your mental health records will be stored, used, disclosed, and how you can obtain access to this information.*
- ❑ **PRINT, COMPLETE, AND BRING** the **Client Information Packet** which includes:
  - ❑ **Client Information Form**
  - ❑ **Client Email Consent**
  - ❑ **Acknowledgment of Receipt of Patient Notification of Privacy Rights**
  - ❑ **Credit Card Authorization Form**
  - ❑ **Agreement to Policies**

A few minutes of the initial appointment will be used to collect your payment for services and discuss the enclosed information with your therapist. If you have any questions or concerns about the information in any of our forms or policies, just bring these forms with you to the session and discuss these with your therapist. We will do our best to help you make an informed decision about entering therapy before you sign these forms.

PLEASE COMPLETE ALL REQUESTED INFORMATION

Life Matters Counseling, PLLC

Client Information Form

CLIENT'S PERSONAL INFORMATION

First Name: ______________________ MI: _____ Last Name: ____________________________

Nickname: ______________________ Date of Birth: _______________ Age: ______

Gender: ❑M ❑F Marital Status: ❑Single ❑Married ❑Other: ______________

Mailing Address: ____ Apt. #__________

City: ______________________________ State: __________ Zip Code: ______________

Church Name: ____

We will need a reasonable way to contact you in case of emergencies, illness, or other relevant events. Unless you authorize us to leave messages, we will only give the name of your therapist and our telephone number. No mention of Life Matters Counseling, PLLC or the nature of the call will be given to the person who takes your message, or on your answering machine / phone. Please initial below to authorize which phones we may call, whether we may leave messages, and which phone you prefer us to try first.

	Initial here to allow calls	Initial here to allow messages	Preferred (check one)
Home Phone: (____) ____________________	______	______	❑
Work Phone: (____) ____________________	______	______	❑
Cell Phone: (____) ____________________	______	______	❑

PERSON RESPONSIBLE FOR PAYMENT: ❑ check if same as above

First Name: ______________________ MI: _____ Last Name: ____________________________

Mailing Address: ____ Apt. #__________

City: __________________ State: ____ Zip Code: _________ Relationship to Client: ______________

Home: ( ) ________________ Work: ( ) ________________ Cell: ( ) ________________

EMERGENCY CONTACT INFORMATION:

Person to Notify in Case of Emergency: ____

Telephone Number(s): ( ) ___________________________ Relationship to Client: ______________

CLIENT'S EMPLOYMENT/SCHOOL INFORMATION:

❑ Full-time ❑ Part-Time ❑ Retired ❑ Unemployed ❑ Other: ____________________

Employer: ____

Occupation: ____

School (if a student): ___________________________ Area of Study: ______________________

IF CLIENT IS UNDER 18 YEARS OF AGE, OR IF THE PARENT(S) WILL BE RESPONSIBLE FOR PAYMENT, COMPLETE THIS SECTION:

Parent's Marital Status: ❑Married ❑Divorced ❑Single ❑Widowed

Mother's Name: ______________________ Telephone/Home: ( ) ___________ Cell: ( ) _____________

Address: ____

City: ____________________________________ State: _____ Zip: ______________

Mother's Employment: _____________________________ Work Telephone: ( ) ____________________

Father's Name: ______________________ Telephone/Home: ( ) ___________ Cell: ( ) _____________

Address: ____

City: ____________________________________ State: _____ Zip: ______________

If divorced, have parents remarried? Mother: Y / N Father: Y / N

Name of the custodial/primary residential party? ____

If step-parents, please furnish names: Step-Mother: __________________ Step-Father: _________________

REFERRAL INFORMATION:

Please tell us how you heard about us and our services: ____

____

(for example: Church/Name; Internet; Medical Doctor/Name; Previous Patient; School/Name; Word-of-Mouth; Other - Please Specify)

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

Name: ____

Address: ____

City: ____ State: ________ Zip Code: ____________

Phone: (___) ____________________

How did this person explain how I might be of help to you? _______________________________________

____

____

____

CLIENT EMAIL INFORMED CONSENT

The Risks of Clients Using E-mail to Communicate with Your Therapist

1. The transmission of client information by email has a number of risks that clients should consider prior to the use of email. These include, but are not limited to, the following risks:
   - Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   - Email senders can easily misaddress an email and send the information to an undesired recipient.
   - Backup copies of emails may exist even after the sender and/or the recipient has deleted his or her copy.
   - Employers and on-line services have a right to inspect emails sent through their company systems.
   - Emails can be intercepted, altered, forwarded or used without authorization or detection.
   - Email can be used as evidence in court.
   - Emails may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.
2. Conditions for the use of email. Life Matters Counseling, PLLC cannot guarantee, but will use reasonable means to maintain, the security and confidentiality of email information sent and received. Life Matters Counseling, PLLC is not liable for improper disclosure of confidential information that is not caused by intentional misconduct. Clients must acknowledge and consent to the following conditions:
   - Email is not appropriate for urgent or emergency situations. Life Matters Counseling, PLLC cannot guarantee that any particular email will be read and responded to within any particular period of time.
   - The client should call and/or schedule an appointment to discuss complex and/or sensitive situations rather than send email regarding such situations.
   - All email communication will be filed into the client's medical record.
   - Life Matters Counseling, PLLC will not forward client's identifiable emails to outside parties without the client's written consent, except as authorized by law.
   - Clients should use their best judgment when considering the use of email for communication of sensitive medical information. Life Matters Counseling, PLLC will not be responsible for the content of messages.
   - Life Matters Counseling, PLLC is not liable for breaches of confidentiality caused by the client or any third party.
   - It is the client's responsibility to follow up and/or schedule an appointment if warranted.
3. Client Acknowledgement and Agreement:

   I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that Life Matters Counseling, PLLC may impose to communicate with me by email.

Client name: ____

Client signature: ____Date: __________

Client Email Address: ____

Our scheduling software allows you the option of having an email reminder sent to the client of record, at least 24 hours before your scheduled appointments. Please indicate whether you would like to participate in this free service. The limits of the system require that the email address **MUST** belong to the person whose name is on the chart.

❑ **Yes, please email me reminders** ❑ **No, please DO NOT email me reminders**

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Acknowledgment of Receipt of Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"); the keeping and use of patient records ("privacy rules"); and, storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care. Providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. Our **Patient Notification of Privacy Rights** document is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship; and, as such, you will find we will do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask us for further clarification.

By law, we are required to secure your signature indicating you have received this **Patient Notification of Privacy Rights** document. Thank you for your thoughtful consideration of these matters.

I understand and have been provided a copy of Life Matters Counseling, PLLC's **Patient Notification of Privacy Rights** document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgement form.

____

Print Name of Client

____ ____________________

Signature of Client or Parent /Guardian *Date*

Relationship to Client of Person Signing this Notification: ___________________________________

If Guardian, describe representative authority: ____

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CREDIT CARD AUTHORIZATION FORM

Life Matters Counseling requires a credit card on file. This will be used only for phone sessions, missed appointments and late cancellation fees.

In addition, you can choose to authorize your therapist to charge your card automatically for sessions that you attend. Because there is an additional banking fee associated with keying vs. swiping credit cards, a **$4.00** per transaction fee will be charged should you choose this option. Your credit card information will be scanned into your confidential medical record that is fully encrypted.

CLIENT NAME: ____

__________ The undersigned card member consents and permits Life Matters Counseling, PLLC, to charge to my credit account fees for phone sessions, late cancellations, missed appointments, or any outstanding balance.

_________ Recurring Charge Authorization: The undersigned card member consents and permits Life Matters Counseling, PLLC, to charge the standard rate for counseling sessions. I understand there will be an additional **$4.00** fee for this convenience. I release my therapist, as applicable, from any and all claims arising from the use of this service. I understand and agree that Life Matters Counseling, PLLC, may continue to charge such amounts to my Credit Card account until receiving notification from me that I have terminated this consent and permission at which time Life Matters Counseling, PLLC, shall cease charging any such amounts to my Credit Card account.

CREDIT CARD NUMBER: ____

EXP DATE: ____________/______________ CVV CODE: (security code): ______________

NAME AS IT APPEARS ON CARD: ____

ZIP CODE OF BILLING ADDRESS: ____

SEND RECEIPT VIA EMAIL: ❑ Yes ❑ No

EMAIL ADDRESS: ____

SIGNATURE: ____ DATE: ___________________

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Agreement to Policies

I have read, understand, and accept the policies, procedures, and conditions outlined in the Life Matters Counseling, PLLC Practice Policies brochure. These include the areas of:

- General information about Life Matters Counseling, PLLC
- The nature of psychotherapy and the benefits/risks
- Appointments
- Professional Fees
- Communication
- What to expect from our relationship
- Confidentiality

One copy of this agreement is for you to keep and the other will be placed in your file at the Life Matters Counseling, PLLC.

____________________________________ ________________

Patient Signature *Date*

____________________________________ ________________

Parent or Guardian if Patient is a Minor *Date*