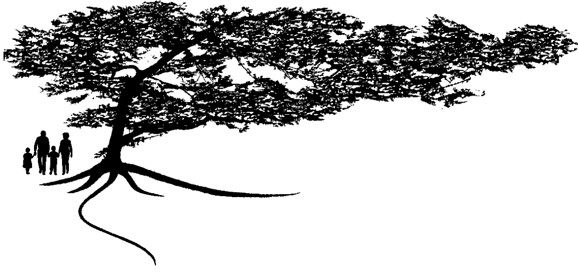

Woodlands Family Institute, P.C.
1610 Woodstead Ct., Suite 420
The Woodlands, TX 77380

(281) 363-4220 Fax: (281) 363-4010
www.wfipc.com

PERSONAL DATA RECORD

Client Name: ______________________________ Date of Birth ______________

Address: ______________________________

City/State/**Zip**: ______________________________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ Other Phone: ______________________

SSN: ______________________ TXDL: ______________________

Employer/School: ______________________________

Referred to Our Office by: ______________________________

May we send a Thank You card to the person who referred you? (Circle One) Yes No
May we mention your name in that Thank You card? (Circle One) Yes No

EMERGENCY CONTACT

Name: ______________________ Relationship: ______________

Address/Phone: ______________________________

CONSENT FOR TREATMENT

Client Name: ______________________________ Birthdate: ______________

I give full consent for **myself** or my **child/adolescent** to receive outpatient mental health services until I notify WFI of any changes or until it is determined that treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for myself or my child/adolescent.

______________________________ ______________________
Signature of *Client, Client's Parent* or *Legal Guardian* Date

AUTOMATIC PAYMENT

If you would like us to automatically charge your credit/debit card for your fee, please provide the information below:

MC/Visa No. ______________________________ Exp. Date ______________

Name as Listed on Card: ______________________________

Signature of Authorized User: ______________________________

FINANCIAL RESPONSIBILITY

Name of person(s) financially responsible for this account: ______________________________

Address(es): ______________________________

Signature(s): ______________________________

Relationship(s) to client: ______________________________

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Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Woodlands Family Institute (WFI) may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *general consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a colleague.
  Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within WFI such as utilizing information that identifies you.
- "*Disclosure*" applies to activities outside of WFI, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation regarding a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Abuse of the Elderly and Disabled:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a therapist:** If you report to us any situation that constitutes sexual misconduct by a current or former therapist, then we are required to inform the licensing authority of the offending therapist.

- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case**.**
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and Our Professional Duties

Client's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeking our services. Upon your request, we will send bills or other correspondence to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Our Professional Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a current copy in our offices. A current copy will always be available on our web site and you may request a personal copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Mary Piehl, Office Manager, or your therapist at (281) 363-4220.

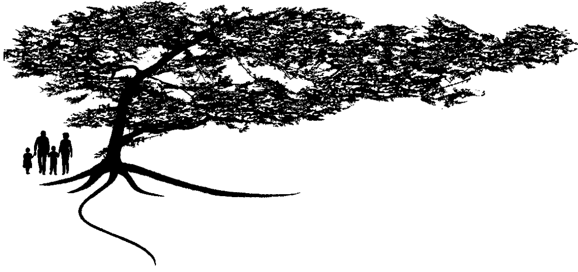
If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Mary Piehl or your therapist at: 1610 Woodstead Ct., Suite 420, The Woodlands, TX 77380.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 3/28/2005. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in our lobby and on our web site. You may request a personal copy at any time.



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Please indicate below how we may contact you and whether we can leave a message:

☐ Home Phone May we leave a message (Circle One)? Yes No

☐ Work Phone May we leave a message (Circle One)? Yes No

☐ Cell Phone May we leave a message (Circle One)? Yes No

☐ Unencrypted (normal) email (address):________________________________

If you would like us to use an address other than your home address for billing and other correspondence, please provide an alternative address below.

Other (Specify) ____

You may change the above instructions at any time by requesting another one of these forms or otherwise instructing us in writing.

ACKNOWLEDGEMENT

I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information** and the **Office Information and Office Policies**. I understand and accept those policies and practices. WFI is hereby granted consent to contact me as specified above, and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

____

Client or Authorized Representative Signature Date

☐ Refused to Sign

☐ Unable to Sign (Specify Reason) ________________________________

____

Signature of Person Documenting Refusal or Inability to Sign Date

Connect, Communicate, and Relate
Lauren Pasqua, Psy.D.
Email: dr.pasqua@woodlandsfamilyinstitute.com | Phone: 281-560-3648

Enclosed you will find the various forms needed for intake. For your first visit I ask that you complete and bring the forms below with you. Having them filled out ahead of time will allow you time to recall the information I'm requesting and will allow me to focus on hearing your "story" during our first meeting rather than paperwork. We cannot meet if it is not completed fully at the time of the session.

Thanks for choosing my practice and I look forward to working with you.

Dr. Pasqua

Psychologist-Client Services Agreement

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and the patient, and the particular problems that you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit where you are prescribed a pill to make your symptoms go away. Instead, it requires a very active effort on your part. In order for psychotherapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involved discussing difficult aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion. You may terminate your services with me at any time, as long as your account is up-to-date. For any concerns about my services, you can contact the Texas Board of Psychology.

Sessions

If psychotherapy is begun, I will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent.

Professional Fees

Service	Description	Fee
Individual or Family Therapy Session	45 minutes	$150 or contracted co-pay
Consultation	Review of records, second-opinion, school advocacy	$150 or contracted co-pay
Psychological Testing	Formal testing for ADHD, autism, diagnostics, learning disabilities, development	Fees dependent on referral questions/needs and are charged per hour at rate of $150. Minimum usually $600
Missed session/late cancellation	Sessions missed or cancelled without 24 hr notice. Not covered by insurance	$150
Returned check	Checks will not be accepted ad payment after 2 bounced checks	$35 per check
Unscheduled phone sessions over 10 minutes	I do not give phone or email sessions. The first 10 minutes of a call are free. You will be billed starting at the 11th minute. Not covered by insurance.	2.50 per minute starting at 11th minute
Attorney, provider, teacher, or other invested 3rd party phone sessions		Minimum charge of $50 for 15 minutes, each subsequent minute 2.50
Letters	i.e. letter to CPS, schools, attorneys. Not covered by insurance	$50 administration fee for 2 pages ($25 for each subsequent page)
Treatment Summary	Clinical note information, treatment dates and times, discharge plan, treatment plan and recommendations, interventions, prognosis, response to treatment, and change in symptoms	$50 administration fee for 2 pages ($25 for each subsequent page)
Meetings	i.e. ARDs, CPS meetings, parent conferences, school observations. Not covered by insurance.	Billed at rate of $160 per hour, portal-to-portal. From my office to location and return to office.
Legal depositions, testimony, or consultation	Time required for travel, preparation, waiting, & expenditures (e.g. copies, parking). Minimum charge for 1 hour. Deposit for legal appearances	$300 per hour $500 due 48 hours before appearance
Standby for court	1 day standby for court proceedings- non-refundable and non-transferable fee Includes 2 hours of testimony; does not include travel expenses	$1000 (due before date of standby)

Legal Testimony

I do not consider my practice to include expert or forensic testimony in any area. I do not conduct forensic assessments. I can provide only factual information as documented in my clinical notes. In the event that I am required to testify before any court, arbitrator, or other

hearing officer, to testify at a deposition, or to present any or all records pertaining to therapy or assessment to a court official, you will be required to pay for all time expended as outlined above. You will also be billed for any acquired expenses for out of town travel (transportation, meals, lodging, etc.).

I required a deposit of $500 24 hours prior to the appearance, records, or testimony requested. The balance of charges is to be paid within 7 days of said appearance, presentation, or testimony. The deposit is not transferrable or refundable if your case is dismissed or continued less than 72 hours prior to the scheduled time.

If I am placed on "standby" for court, I cannot schedule appointments for that day. Standby fee is $1000 and is not transferrable to another day and non-refundable. The fee will cover 2 hours in court, but you will be billed at $150 per hour for each additional hour in court.

Billing and Payments

You will be expected to pay for each session at the time that it is held, unless we agree otherwise or you have insurance coverage that requires another arrangement. Cash, check and all major credit cards accepted for payment. I require a deposit at the time of psychological testing with payment in full expected by the time the results are presented in the formal report and feedback session.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release is a client's name, the nature of services provided, and the amount due. (If such legal action is necessary, its costs will be included in the claim.)

Insurance Reimbursement

If I am a provider for your insurance then I will fill out forms and provide you with whatever assistance I can in helping you receive benefits to which you are entitled; however **you** (not your insurance company) are ultimately responsible for full payment of my fees.

Managed Health Care plans such as HMOs and PPOs often require authorization and an "eligible" diagnosis before they provide reimbursement for mental health services. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end.

Although HIPPA protects patient records, insurance companies often request information about patients' treatment. At a minimum, they usually require a clinical diagnosis, dates of service, and type of service. Other companies request treatment plans, detailed reports, or even copies of progress notes. This information becomes part of your file with the insurance company and may be stored in a computer database, or possibly shared with a national medical information database. I have no control over the use and distribution of your private health information once it leaves my office. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

Contacting Me

Due to my work schedule, I am often not immediately available by telephone. I will make every effort to return your call on the same day that you make it, with the exception of weekends and holidays. If you are unable to reach me and it is an emergency, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

Email
Email and other forms of electronic communication are not secure or confidential. If you choose to communicate with me via email you are agreeing to accept the limits to confidentiality that are inherent in electronic communications. Please DO NOT email to cancel appointments as I do not monitor my email for cancellations. Also, please refrain from including detailed personal information in messages. Emails are to be primarily used in scheduling and payment discussions.

Confidentiality & Privacy Policy
The law protects the relationship between a client and a psychologist, and I cannot disclose information about you without your written permission; however, there are a few legal exceptions to this rule. 1) when a client is likely to harm himself/herself or others 2) when there is reasonable suspicion of child or elder abuse 3) when there is a valid court order 4) With your permission, to bill third-party payers (insurance). Please read and sign the provided information about privacy and HIPAA laws.

Appointments
I do not usually call to confirm appointments. Your appointment time has been specifically reserved for you. If you cannot keep a scheduled appointment, please cancel the appointment **at least 24 hours in advance**.

Cancellation Policy
If you do not show up for your scheduled therapy appointment, and you have not notified me at least **24 hours** in advance, you will be required to pay the full cost of the session. Appointment times are set aside specifically for you and missed appointments reduce my capacity to provide services to other clients, as the number of appointment times are limited, especially during peak hours (e.g. evenings).

Please note that insurance companies do not pay for missed sessions; therefore, you will be personally responsible for full payment of fees for that time. If you miss or re-schedule several consecutive appointments, we will need to re-evaluate our therapeutic relationship. This may mean that we can no longer work together or that the current time is not right for you to engage in therapy.

By signing below I acknowledge that I have read and agree to adhere to all the policies described above. I agree to pay for my services at the above outlined rates.

__________________________________ ________________________
Client's Signature Date

Adult Intake Form

Identifying Information/Presenting Problem:

Name_________________________________ Date of Birth:_____________________

Age:_________________________ Date of Evaluation/Intake:__________________________

Who referred you:____

Presenting

Problem:____

Family History:

Current Members of the Household:

Name Age Relationship How do they get along with others in home?

1____

2____

3____

4____

5____

6____

Describe your relationships with household members:______________________________________

____

Number of children and ages:____

Where are any children outside of the home?:____

____

Are you currently married or with a partner?_________ Length of this relationship?__________

History of separations or divorce?____

Describe what your relationships have been like with significant others (partners)___________

____

Parenting:

How do you view your parenting skills?____

What do you need to improve as a parent?____

What do you use for discipline?____

Have you used physical discipline? Explain:____

Have you ever had problems providing the basic needs for your children (utilities, food, clothing, housing)

Describe:____

Family of Origin:

Please describe your childhood:____

Describe your current and past relationship with your mother :______________________________

____

Describe your current and past relationship with your father:______________________________

____

Does either of your parents (or caregivers) have drug or alcohol use/abuse now or in the past? Describe: ____

Does either of your parents (or caregivers) have domestic violence issues or significant conflict? Describe:____

How many brothers and sisters do you have? __________ Describe your relationships with siblings?____

Does anyone in your extended family (siblings and parents) have a history of mental health problems? Describe:____

____

History of Trauma:

Please **check** and **describe** any of following that have occurred anytime in your life, either as the victim or as a witness:

( ) Physical Assault or Abuse:____

( ) Emotional Abuse:____

( ) Domestic Violence or Exposure to Physical Conflicts:____________________________________

( ) Neglect (Not having basic needs met):____

( ) Sexual Abuse: ____

Describe anything else you have experienced that may have been traumatic or greatly impacted you in your life:____ _____

____

____

Social/Emotional Functioning

Describe your personality:____

____

What would you like to change about yourself?____

How do you deal with frustration?:____

Do you feel you have anger issues? Describe:____

What are your strengths?:____

What are your weaknesses?____

What are your fears (what are you afraid of)?____

How many close friends do you have? ___________ What do you do with friends?______________

Describe your relationships with others:____

How do you spend your free time?____

Legal History

Please list and explain any legal charges you have had (even if the charges were reduced or dropped), include dates:____

____

Have you ever been: ( ) on probation ( ) on parole ( ) incarcerated ? Provide reason and dates:

____

____

Please describe if you have any family or friends (current or past) that have legal charges:

____

____

Substance Use:

How often do you drink alcohol? ____________________How much per sitting?__________________

Have you ever used or abused any drugs in your life? Describe:______________________________

____

Have you ever had any treatment related to substance use? Describe: ________________________

____

Do you smoke cigarettes? ( )Yes ( )No Amount per day?_____________________________________

Please indicate if you have any family or close friends (current or past) who have an alcohol or drug problem:____

Medical History:

Significant medical problems during childhood:____

Current health and medical problems: ____

(Past: include age):____

Current medications:____

Past medications for behavioral/emotional problems: _____________________________________

____

Other medical history:____

Describe your sleeping patterns:____

Is there a history of nightmares? (Describe):____

Describe your eating patterns:____

Mental Health History:

What current mental health services (counseling and/or psychiatrist) are you receiving?___

What mental health services have you received in the past? (include dates):___

___

What have you been diagnosed with (current or past)? ___

Have you ever received a psychological assessment in the past?___

Date:___ Results of testing:___

Have you ever thought about or attempted to harm yourself or someone else?

Describe:___

___

Circle which mental health services you feel would assist in addressing the current difficulties? Individual Therapy Group Therapy Family Therapy

Medication Management Other:___

Employment & Educational History:

Current Employment:___

Amount of time at current employment:___

How many hours do you work in a typical week?___ Approximate Income:___

If not employed, how long have you been without work and explain why?___

___

How many jobs have you had in the last 5 years? (describe):___

Describe your current level of job satisfaction:___

Describe your relationship with others at your job:___

Highest Level of Education: ___

Did you have any learning difficulties in school?___

Did you have frequent discipline problems while in school? Explain:___

___

Daily Living:

Describe your daily activites:___

___

Do you have difficulties managing money?___

Number of hours your watch television or use computer for leisure per day:___

Do you prepare your own meals or eat out often?:___

Do you have transportation? (Describe):___

Describe general housekeeping duties you perform weekly:______________________________

Do you have your own housing? Explain:____

How many different homes have you lived in over the last 5 years?_____________________

Are there any history of developmental delays, explain:___________________________________

Please check all symptoms that apply: (Please write any symptoms not listed at the bottom)

____ Low Intelligence
____ Learning Problems
____ Social Isolation
____ Lack of Eye Contact
____ Obsession with Specific Topics/thoughts
____ Loss of Energy
____Attention Problems
____Problems Listening
____Problems with Organization
____Losing Things Easily
____Distracted Easily
____Forgetful
____Excessive Energy
____Impulsive/Acting without Thinking
____Excessive Talking (e.g. sex, shopping, etc.)
____ Pounding Heart, Increased Heart Rate
____ Sweating
____ Shaking or Trembling
____ Feeling Like Choking
____Cruel to Animals
____Stealing
____Frequent Lying
____Damaging Own or Others Property
____Getting into Frequent Arguments
____Losing Temper Easily
____Feeling Angry Often
____Hearing Voices
____Seeing Things Others Don't
____Paranoia (feel others are out to get you)
____ Other Repetitive Behaviors
____Gambling Problems
____ History of Trauma or Abuse
____Excessive/Binge Eating
____Making Yourself Vomit or Use of Laxatives
____Excessive Dieting or Exercise
____ Extreme Startle Response (jumpiness)

____ Depressed Mood
____ Lack of Pleasure in Activities
____ Weight Loss or Gain
____ Insomnia or Oversleeping
____ Feeling Restless or Slowed Down
____ Feeling Worthless or Guilty
____ Poor Concentration
____ Thoughts of Death
____ Increased Self Esteem
____ Less Need for Sleep
____ More Talkative than Usual
____ Racing Thoughts
____ Increased Pleasurable Activities
____Interrupting Others
____Bullying/Threatening Others
____Getting into Fights
____Harmed or Threatened with Weapon
____ Chest Pain
____ Nausea and/or Stomachaches
____ Feeling Dizzy, Lightheaded, or Faint
____ Feeling Like You are Going Crazy
____ Fear of Dying
____ Chills or Hot Flashes
____ Fear of Leaving the House
____ Fear of Social Situations
____ Recurrent Thoughts or Images
____ Constant Worrying or Nervousness
____ Repetitive Handwashing, Cleaning, etc.
____Sexual Problems
____Identity or Gender Issues
____ Fear Related to Trauma or Abuse
____ Recurrent Thoughts Related to Trauma
____ Avoiding Situations Related to Trauma
____ Blocking Out Memories of Trauma
____ Sleep Problems and/or Nightmares