BARBARA NADALINI PRIESNITZ, MA, LPC

PSYCHOTHERAPY & HYPNOSIS

CLIENT INFORMATION			
Full Name			
DOB			
Cell Phone Number		Cellphone Carrier:	
Email Address			
Home Address			
Is it okay to text / email you?			
How did you hear about me?			
Why are you coming to therapy?			
Physical Health Issues:			
Emotional Health Issues:			
Please list all Medications:			
Employment:			
Hobbies / Interests:			
Relationship Status:			
Spirituality?			
Substance Abuse?			
Emergency Contact (name / relationship / #)			

512-786-6497 (CELL)
866-201-1481 (FAX)

barbara@BNPsychotherapy.com
2101 HIGHGROVE TERRACE, AUSTIN 78703

BARBARA NADALINI PRIESNITZ, MA, LPC
PSYCHOTHERAPY & HYPNOSIS

INFORMED CONSENT

Training and Background
I am licensed by the Texas State Board of Examiners of Professional Counselors as a Licensed Professional Counselor, (#71515), and hold a Master's degree in Counseling Psychology (2010).

Confidentiality
Texas State law requires me to inform you that in certain cases your confidentiality is not protected, and your information may be disclosed to the appropriate authorities/agencies. These cases are: 1. If I have reason to believe that you may harm yourself or others, 2. If I have 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, or 3. If I am ordered to disclose by State or Federal courts.

Therapeutic Relationship
A strong relationship between therapist and client is developed over time, and can be emotionally close and meaningful. However, it is a professional relationship governed by state law and ethics practices, in which appropriate boundaries must be maintained. This prevents us from having a social relationship or friendship outside of the therapy session, including on social media. These boundaries ensure that your therapy is safe, secure, and free of outside complications that could interfere with your therapy.

Session Guidelines and Fees
Payment-in-full is due at the time services are rendered, or at the time of booking if the online booking system is used. Each session is 50 minutes, unless a longer duration has been scheduled in advance. Late arrival on your part will not extend the scheduled ending time. Services and fees are listed on my website at www.BNPsychotherapy.com, and are occasionally are updated. You will be given 60 days' advance notice of any fee increase. Fee increases will not occur more than once in any 12-month period.

Cancellation
24 hours' notice is required to cancel an appointment without incurring a full-fee charge. If you provide sufficient notice to cancel, you will not be charged. If you do not provide sufficient notice to cancel, or you miss your appointment, your on-file credit card will be charged for the agreed fee for service, or you will receive a bill via PayPal if there is no credit card on file. If you miss or late-cancel, the charge will be processed on the day of the scheduled session, but I may be able to fit you in later in the week for no additional charge, subject to availability and at my discretion.

Outside Contact and Emergencies
I check my phone messages and email daily or more frequently; however, during the workday I may not be able to respond except between sessions or at the end of the day. If you send me a very lengthy communication, I may not read it until our next session when we can discuss it together. Please do not text me or call me between 9:00 pm and 9:00 am. ***In case of an emergency, please call 911, or the 24-hour crisis hotline at 472-HELP (472-4357).***

I acknowledge that I have had the opportunity to review this "Informed Consent" used by Barbara Nadalini Priesnitz, MA, LPC, and that I may request a copy of this information sheet at any time.

Signature / Date:	

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PRIVACY NOTICE

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

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

I may *use* or *disclose* your *protected health information* (PHI) for *treatment, payment, and health care operations* purposes with your *consent.* To help clarify these terms, here are some definitions: ·"PHI" refers to information in any health care records I maintain regarding you that could identify you. ·"Treatment, *Payment and Health Care Operations"; Treatment* is when I 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 another psychotherapist; *Payment* is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to any third party payor 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 my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you; ·"Disclosure" applies to activities outside my practice such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I 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 permitting specific disclosures above and beyond those permitted by the general consent. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes.; *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session which I have kept separate from the rest of your individual record. Under Federal law, these notes are given a greater degree of protection than PHI; You may revoke all such authorizations (regarding PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I 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

I may use or disclose PHI without your consent or authorization in the following circumstances: ·**Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of this belief within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or any local or state law enforcement agency; ·**Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report this belief to the Department of Protective and Regulatory Services; ·**Health Oversight:** If a complaint is filed against me with the Texas State Board of Examiners of Professional Counselors, they have the authority to subpoena confidential mental health

information from me 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. I will not release such information unless I have either written authorization from you or your personal or legally appointed representative or else 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 I 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, I may disclose relevant confidential mental health information to medical or law enforcement personnel. ·**Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Your Rights:

·Right *to Request Restrictions.* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am 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 seeing me. Upon your request, I will send any mail to you at another address that you provide me;) ·Right *to Inspect and Copy.* You have the right to inspect or obtain a copy (or both inspect and obtain a copy) 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. I may deny your access to PHI or to psychotherapy notes under certain circumstances, but in some cases you may have this decision reviewed. On your request, I 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. I may deny your request. On your request, I 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 provided neither consent nor authorization (as described in Section III of this Notice). On your request, I 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.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me; If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me at the address provided on my letterhead. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services or to the Texas Board of Examiners of Professional Counselors, 1100 W. 49th St., Austin, Texas 78756-3183, 512-834-6658.

Acknowledgement of Review of Privacy Information Protection Policies

I acknowledge that I have had the opportunity to review this "Privacy Notice" used by Barbara Nadalini Priesnitz, MA, LPC. I understand that I may request a copy of this information sheet at any time.

Signature / Date:	

BARBARA NADALINI PRIESNITZ, MA, LPC
PSYCHOTHERAPY & HYPNOSIS

CREDIT CARD AUTHORIZATION AGREEMENT

1. By providing my credit card information below, I authorize Barbara Nadalini Priesnitz, MA, LPC to charge my card for completed attendance at appointments or classes, or appointments or classes canceled without 24 hours' notice, or missed without notice.
2. I agree to pay for therapy sessions for each person, couple or family listed in the "Client(s)" field below, at the fee listed below.
3. This authorization can be modified or canceled at any time by sending Barbara an email specifying the change or cancellation at barbara@BNPsychotherapy.com.
4. If I am using a credit card belonging to another person (e.g. parent or spouse), my signature below certifies that I have permission from the cardholder to use the card for this purpose. (Note: If receipts are to be sent to another person, an Authorization to Release Information will be required).

Client(s):			Fee:
Name on Card:			
Credit Card #:			
Expiration Date:		CVC:	Zip Code:
Signature:			
Date:			

NOTE: Credit Card line item charges may refer to MindBody and/or Barbara Nadalini Priesnitz, depending on your credit card issuer and their use of data. Please contact our office directly if you have any questions or concerns about credit card charges.

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