Corey D. Allan, Ph.D. and Associates
Licensed Marriage and Family Therapist
Licensed Professional Counselor

PROFESSIONAL DISCLOSURE STATEMENT
Therapy Policies and Services

Welcome! I am committed to providing you with quality care. This information packet is intended to acquaint you with what you can expect, and address some of the typical areas of concern, especially for the first-time client.

Qualifications: I am a graduate from Texas Woman's University in Family Therapy and the University of North Texas in Counselor Education. I am qualified to counsel according to the Texas Department of Health. My formal education has prepared me to counsel individuals, groups, couples, parents, and families. I am a member of the American Association of Marriage and Family Therapists and American Association of Christian Counselors.

Experience: Throughout my doctoral and master's program and under supervision since completing my formal education I have counseled many individuals, couples, families and conducted many groups. I am also a certified trainer in the Love and Limits Parenting approach from the Savannah Family Institute.

INFORMED CONSENT

Counseling Relationship: While we work together, our sessions may be very intimate psychologically, but ours is a professional relationship rather than a social one. Please do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling sessions. You will be best served if our sessions concentrate exclusively on your concerns.

Our in-person contact will be limited to counseling sessions you arrange with me. You may leave messages for me at 214-629-6133 and I will return your call as soon as possible. If you experience a mental health emergency, obtain crisis services by calling 911 and/or by going to a nearby hospital emergency room.

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Client Rights: Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might be harmful.

I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the Texas Department of Health, 512-834-6658.

Conditions of Ongoing Counseling: If you have been in counseling or psychotherapy during the past seven years, I may require you to sign a release so I may communicate with and/or receive copies of records from the professional(s) from whom you received mental health services. While you are in counseling with me you agree not to maintain or establish a professional relationship with another mental health professional unless you first discuss it with me and sign a release that enables me to communicate with the other mental health professional(s). If you decide to maintain or establish a professional relationship with another mental health professional against my advice, I may consider this your decision to change counselors and I reserve the right to terminate your counseling.

I also reserve the right to postpone and /or terminate counseling of clients who come to session under the influence of alcohol or drugs. In addition, I reserve the right to terminate counseling of clients who do not comply with the medication recommendations of their psychiatrist or physician.

Referrals: I recognize that not all conditions presented by clients are appropriate for treatment at this facility. For this reason, you and/or I may believe that a referral is needed. In that case, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those

 Initials _____

referrals and /or alternatives. Certain aspects of treatment may require evaluation through psychological testing or medication. In such cases, a referral to a psychiatrist or medical doctor may be made. Ongoing dialogue with these professionals would be maintained to manage the counseling process effectively.

Fees: In return for the package you select, I agree to provide counseling services for you. If the package fee represents a hardship to you, please let me know. The fee for each session will be due and must be paid by the conclusion of each session. Cash or personal checks made out to "*Dr. Corey Allan*" are acceptable for payment. If you become involved in litigation that requires my participation, and due the complexity and difficulties of legal involvement, I charge *double* my session rate per hour for preparation for and/or attendance at any legal proceedings.

Cancellation: In the event that you will not be able to keep an appointment, please notify me at least **24 hours** in advance, whenever possible. **Failure to do so will result in you being billed your normal rate for the missed session**. If you intend to discontinue counseling, please inform me immediately so a termination session can be scheduled and your case closed.

Format: Most sessions will be weekly and will last between 45 to 50 minutes.

Records and Confidentiality: All of our communication becomes part of the clinical record. Adult client records are disposed of seven years after the file is closed. Minor client records are disposed of seven years after the client's 18th birthday. Most of our communication is confidential, but the following limitations and exceptions do exist: a) I am using your case records for purposes of supervision and professional development. In such cases, to preserve confidentiality, I will identify you by first name only; b) I determine that you are a danger to yourself or someone else; c) you disclosed abuse, neglect, or exploitation of a child, elderly, or disabled person; d) you disclose sexual contact with another mental health professional; e) I am ordered by a court to disclose information; f) you direct me to release your records; or g) I am otherwise required by law to disclose information. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

In the case of marriage or family counseling, I will keep confidential (within limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to the therapeutic progress.

_____ _____
Client's Signature Counselor's Signature

_____ _____
Client's Signature Date

 Initials _____

Corey D. Allan, Ph.D. and Associates
Licensed Marriage and Family Therapist
Licensed Professional Counselor

GENERAL INFORMED CONSENT FOR THERAPY

Clients usually enter counseling because they seek some positive benefits. Psychotherapy and counseling have some risks as well as benefits. Just talking about your history and concerns can have both positive and negative effects. I want to inform you of the possible risks as well the potential benefits as you begin therapy. During the first session, I will confirm with you in writing your understanding of the limits of confidentiality, the risks and benefits of verbal therapy, and the expectations of you as a client.

I will determine with you the methods, goals, or objectives of your counseling after I have collected some of the history regarding the issues. Any type of therapy will have certain benefits and specific risks associated with it. When I recommend a definite type of therapy, I will discuss the reasons for choosing that type of method. I will also discuss any additional benefits as well as risks associated with my recommendations. If the situation warrants, I may recommend other types of care including a referral to your family physician for an evaluation. It is your decision whether to follow my recommendation.

Regarding online therapy and consultations, every effort will be made to protect our communications and our sessions. But it must be noted, as with all online communication, some risks may still be present. Regarding any conversations we have via email, it is best to keep communication brief, as most emails servers are not secure. Regarding our sessions online, while Skype and Google Talk are encrypted, there is still a slight risk involved with our conversations. With these noted exceptions, every step has been, and will be taken to ensure confidentiality.

I have reviewed the risks and benefits of general verbal therapy as explained in this document. My therapist has adequately answered any questions I have regarding these risks and benefits. I agree to enter verbal therapy with an understanding of the possible risks. I further understand that my therapist will explain any additional specific risks and benefits associated with any particular method, goals or objectives he may recommend.

_____	_____	_____
Client name (Print)	Signature	Date
_____	_____	_____
Client name (Print)	Signature	Date

I have interviewed the above named individual(s) and have answered any questions about the risks and benefits of general verbal therapy. On the basis of my interview I have no reason to believe that he/she or they are not competent to understand the nature of verbal therapy and the potential risks and benefits that may result from it.

__Corey D. Allan, Ph.D._____	_____	_____
Provider name	Signature	Date

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

I am required by law to maintain the privacy of your protected health information (PHI) and to provide you with notice of your privacy rights and my legal duties and privacy practices with respect to your PHI. I am required to abide by the terms of this notice with respect to your PHI but reserve the right to change the terms of this notice and make the new notice provisions effective for all PHI that I maintain. I will provide you with a copy of the revised notice sent by regular mail to the last address you have provided to me for this communication purpose.

Understanding Your Personal Health Information

Each time you visit a hospital, physician, mental health professional or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, in

 Initials _____

the case of a mental health professional, therapy notes, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of this practice, the facility that compiled it, the information belongs to you. You have the following privacy rights:

1. The right to request restrictions on the use and disclosure of your PHI to carry out treatment, payment, or health care operations.
You should note that I am not required to agree to be bound by any restrictions that you request but am bound by each restriction that I do agree to.
2. In connection with any patient directory, the right to request restrictions on the use and disclosure of your name, location at this treatment facility, description of your condition and your religious affiliation. (I do not maintain a patient directory.)
3. To receive confidential communication of your PHI unless I determine that such disclosure would be harmful to you.
4. To inspect and copy your PHI unless I determine in the exercise of my professional judgment that the access requested is reasonably likely to endanger your life or physical safety (Note: if state law allows, emotional safety may be included as well) or that of another person.
You may request copies of your PHI by providing me with a written request for such copies. I will provide you with copies within ten (10) business days of your request at my office. You will be charged $.15 for each page copied and you will be expected to pay for the copies at the time you pick them up.
5. To amend your PHI upon your written request to me setting forth your reasons for the requested amendment. I have the right to deny the request if the information is complete or has been created by another entity.
I am required to act on your request to amend your PHI within sixty (60) days but this deadline may be extended for another thirty (30) days upon written notice to you. If I deny your requested amendment, I will provide you with written notice of my decision and the basis for my decision. You will then have the right to submit a written statement disagreeing with my decision, which will be maintained with your PHI. If you do not wish to submit a statement of disagreement, you may request that I provide your request for amendment and my denial with any future disclosures of your PHI.
6. Upon request, to receive an accounting of disclosures of your PHI made within the past 6 years of your request for an accounting. Disclosures that are exempted from the accounting requirement include the following:

- Disclosures necessary to carry out treatment, payment, and health care operations.
- Disclosures made to you upon request.
- Disclosures made pursuant to your authorization.
- Disclosures made for national security or intelligence purposes.
- Permitted disclosures to correctional institutions or law enforcement officials.
- Disclosures that are part of a limited data set used for research, public health, or health care operations.
  I am required to act on your request for an accounting within sixty (60) days but this deadline may be extended for another thirty (30) days upon written notice to you of the reason for the delay and the date by which I will provide the accounting. You are entitled to one (1) accounting in any twelve (12) month period free of charge. For any subsequent request in a twelve (12) month period, you will be charged $.25 for each page copied and you will be expected to pay for the copies at the time you pick them up.

7. To receive a paper copy of this privacy notice even if you agreed to receive a copy electronically.

 Initials _____

8. The right to complain to me and to the Secretary of the U.S. Department of Health & Human Services (HHS) if you believe your privacy rights have been violated. You may submit your complaint to me in writing setting out the alleged violation. I am prohibited by law from retaliating against you in any way for filing a complaint with HHS or me.

USES & DISCLOSURES

Your written authorization is required before I can use or disclose my therapy notes which are defined as my notes documenting or analyzing the contents of our conversations during our counseling sessions. Therapy notes do not include medication prescription and monitoring, results of clinical tests and any summary of the following items: diagnosis or the treatment plan. It is my policy to protect the confidentiality of your PHI to the best of my ability and to the extent permitted by law. There are times however, when use or disclosure of your PHI including, therapy notes, is permitted or mandated by law even without your authorization.

Situations in which I am not required to obtain your consent or authorization for use or disclosure of your PHI therapy notes) include the following circumstances:

- By me or my office staff for treatment, payment or health care operations as they relate to you.

Examples:
Information obtained by me will be recorded in your record and used to determine the course of treatment that should work best for you. I will document in your record our work together and when appropriate I will provide a subsequent counselor or healthcare provider with copies of various reports that should assist him or her in treating you once we have terminated our therapeutic relationship.

A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.
- In the event of an emergency to any treatment provider who provides emergency treatment to you.
- To defend myself in a legal action or other proceeding brought by you against me.
- When required by the Secretary of the Department of Health & Human Services in an investigation to determine my compliance with the privacy rules.
- When required by law in so far as the use or disclosure complies with and is limited to the relevant requirements of such law.

Examples:
To a public health authority or other government authority authorized by law to receive reports of child abuse or neglect.
If I reasonably believe an adult individual to be the victim of abuse, neglect or domestic violence I may report to a governmental authority, including a social services agency authorized by law to receive such reports to the extent the disclosure is required by or authorized by law or you agree to the disclosure and I believe in the exercise of my professional judgment, disclosure is necessary to prevent serious harm to you or other potential victims. If I make such a report, I am obligated to inform you unless I believe informing you will place the individual at risk of serious injury.
In the course of any judicial or administrative proceeding in response to:
- an order of a court or administrative tribunal so long as only the PHI expressly authorized by such order is disclosed
- a subpoena, discovery request or other lawful process, that is not accompanied by an order of a court or administrative tribunal so long as reasonable efforts are made to give you notice that your PHI has been requested or reasonable efforts are made to secure a qualified protective order, by the person requesting the PHI
- child custody cases and other legal proceedings in which your mental health or condition is in issue, are the kinds of suits in which your PHI may be requested.
- In addition, I may use your PHI in connection with a suit to collect fees for my services.
- In compliance with a court order or court ordered warrant, or a subpoena or summons issued by a judicial officer; a grand jury subpoena or summons, a civil or an authorized investigative demand or similar process authorized by law provided that the information sought is relevant and material is provided for a legitimate law enforcement inquiry, the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought and de-identified information could not reasonably be used.

 Initials _____

- To a health oversight agency for oversight activities authorized by law as they may relate to me (i.e. audits; civil, criminal or administrative investigations, inspections, licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions.)
- To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- To funeral directors consistent with applicable law as necessary to carry out their duties with respect to the decedent.
- To the extent authorized by and the extent necessary to comply with laws relating to workers compensation or other similar
  programs established by law.
- If use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- To a public health authority that is authorized by law to collect or receive such information for the purposes of preventing or controlling a disease, injury or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth, death, and the conduct of public surveillance, public health investigations, and public health interventions.
- To a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading a disease or condition, if the covered entity or public health authority is authorized by law to notify such persons
  as necessary in the conduct of a public health intervention or investigation.
- To a public health authority or other appropriate governmental authority authorized by law to receive reports of child abuse or neglect.
- To a law enforcement official if I believe in good faith that the PHI constitutes evidence of criminal conduct that occurs on my premises.
- Using my best judgment, to a family member, other relative or close personal friend or any other person you identify, I may
  disclose PHI that is relevant to that person's involvement in your care or payment related to your care.
- To authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act and implementing authority.
- To Business Associates under a written agreement requiring Business Associates to protect the information. Business Associates are entities that assist with or conduct activities on my behalf including individuals or organizations that provide legal, accounting, administrative, and similar functions.

I may contact you with appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. If you have any questions and would like additional information, you should bring this to my attention at the first opportunity. I am the designated Privacy Officer for my practice and will be glad to respond to your questions or request for information.

Please indicate the way(s) you consent for the undersigned counselor to communicate with you, and please notify the counselor immediately of any changes:

Home phone: _____ Message? Yes/No
Cell phone: _____ Message? Yes/No
Work phone: _____ Message? Yes/No
Mail: _____
Email: _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby assign, transfer and set over to Provider, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy.
I authorize the release of any medical information needed to determine benefits, including medical, surgical, psychiatric, and /or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company, or of any balance due after payments by my Insurance Company.

 Initials _____

Client/Guardian Signature_____ Date_____

Client/Guardian Signature_____ Date_____

Witness Signature_____ Date_____

Client verification of receipt of
Notice of Privacy Practices

I understand that as part of my healthcare, the undersigned therapist originates and maintains health records describing my health history, symptoms, evaluations and test results, diagnosis, treatment, therapy notes, and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The Notice of Privacy Practices for Simple Marriage (Corey D. Allan, PhD, LPC, LMFT) provides specific information and a thorough description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the Notice of Privacy Practices. Before implementation of any revised Notice of Privacy Practices, the revised Notice will be mailed to me at the address I designate in this document. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare operations and that I am not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Simple Marriage (Corey D. Allan, PhD, LPC, LMFT) has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. I have been provided and have received the Simple Marriage (Corey D. Allan, PhD, LPC, LMFT) Notice of Privacy Practices.

____There are no legal orders or courses of action that prevent me from consenting to treatment for myself or the minor child in my care.

____There are legal orders or courses of action regarding myself or the minor child in my care.

BY SIGNING THIS FORM, I AM DECLARING THAT I HAVE THE LEGAL AUTHORITY TO SOLELY CONSENT TO TREATMENT FOR MYSELF AND/OR THE MINOR CHILD IN MY CARE.

_____ _____
Client name (please print) Date of birth

_____ _____
Signature of Client or Legal Representative Date

_____ _____
Client name (please print) Date of birth

_____ _____
Signature of Client or Legal Representative Date

Witnessed:

_____ _____
Corey D. Allan, PhD, LPC, LMFT Date

 Initials _____

INTAKE FORM

Name of Client _____

Social Security No. _____ Drivers License No. _____ State: _____

Date of Birth _____ Age _____ Sex _____ Race _____ Religion _____

Street Address _____ Home Phone _____

City _____ Zip _____ Cell Phone _____

Email _____

Employer _____ Work Phone _____

Job Title _____ Education (Yrs Completed)_____

Marital Status (Circle): Single / Married / Separated / Divorced / Widowed / Cohabitating

Name of Spouse _____ No. of years married _____

Spouse Information (if applicable)

Date of Birth _____ Age _____ Sex _____ Race _____ Religion _____

Street Address _____ Home Phone _____

City _____ State/Zip _____ Work Phone _____

Employer _____ Education (Yrs. Completed)_____

Job Title _____

Children

Full Name	**Sex**	**Age**	**Comments**

Who is currently living in your home?

_____

Who referred you to counseling? _____ _____ Referral Date _____

How did you find me? _____

Why are you currently seeking counseling? _____

_____

_____

List your current concerns in the order of their importance _____

_____

_____

 Initials _____

Is there a history of any of the following? (Please circle all that apply)

Suicide Attempts
Major Depression
Anxiety
Domestic Violence
Drug or Alcohol Abuse (Self or Family)
ADD / ADHD
Grief Issues
Sexual Abuse
Contact with Child Protective Services or similar agency
Other_____

What do you hope to gain from counseling at this time? _____

_____

Have you had any previous counseling? _____ If so, where and when and with regard to what issues?

Name of previous therapist _____ Address _____

Dates of therapy? From _____ To _____ City _____ State/Zip _____

Issues of concern

_____

Reason for termination of therapy

_____

Medical History

Physician's Name _____

Address _____ City _____ State/Zip _____

Current Medications

_____

_____

Check the behaviors and symptoms that occur to you more often than you like them to take place:

_____ aggressions
_____ alcohol dependence
_____ anger
_____ antisocial behavior
_____ anxiety
_____ avoiding people
_____ chest pain
_____ depression
_____ disorientation
_____ distractibility
_____ dizziness
_____ drug dependence
_____ eating disorder
_____ elevated mood
_____fatigue
_____hallucinations
_____heart palpitations
_____high blood pressure
_____hopelessness
_____impulsivity
_____irritability
_____judgment errors
_____loneliness
_____memory impairment
_____mood shifts
_____panic attacks
_____phobias/fears
_____recurring thoughts
_____ sexual difficulties
_____sick often
_____sleeping problems
_____speech problems
_____suicidal thoughts
_____thoughts disorganized
_____trembling
_____withdrawing
_____worrying
_____other (specify)
_____cutting
_____
_____
_____

List additional illness, physical conditions or complaints:

_____

_____

Initials _____