Carla J Wynn MSW LCSW DCSW

Psychotherapist
2219 Sawdust Road, Ste. 701
The Woodlands, Texas 77380
281-516-5745

PERSONAL DATA RECORD

Client Name_____Date of Birth _____

Address_____

City/State/Zip _____

SSN_____TXDL _____

Employer/School/Address _____

May we leave a message at any of the following?	**Please circle**	
Home phone _____	Yes	No
Work phone _____	Yes	No
Cell phone _____	Yes	No
Unencrypted email address _____	Yes	No

*** Please do not cancel appointments via email. You must contact the office directly.**

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

Other _____

Referred to our office by _____

May we send a **thank you** to the person who referred you?	Yes	No
May we mention your **name** in that thank you?	Yes	No

Credit Card Payment Authorization for Auto Charge

Name_____ Relationship_____

Address_____

Phone_____

Credit Card No._____Exp. Date_____CVV_____

Name as listed on Card _____

Signature of Authorized User _____

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Financial Responsibility

Name of person(s) financially responsible for this account _____

Address/phone if different from client _____

_____

_____

Signature(s)_____

Relationship to client _____

Emergency Contact

Name_____ Phone_____

Alternate phone _____ Address_____

_____

Relationship to client _____

You may change the above instructions at any time by requesting another form or otherwise instructing in writing.

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Appointment Reminder

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your phone (via a computer generated voice message) the day before your scheduled appointments.

Your name: (please print) _____

Your email address: _____

Your cell phone number: _____

Your cell phone carrier (circle one):

Alltel AT&T Boost Mobile Nextel Sprint SunCom

T-Mobile Verizon VoiceStream Virgin Mobile (Other): _____

Where would you like to receive appointment reminders? (Check one)

_____Via a text message on my cell phone (normal text message rates will apply)

_____Via an email message to the address listed above

_____Via an automated telephone message to my phone

_____None of the above, I'll remember my appointments on my own.

****Missed appointment fees will still apply. 24 hour cancellation policy still applies. Please call the office if you need to cancel an appointment. ****

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

---------- ----------

Signature Date

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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. Carla J Wynn LCSW DCSW 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

Refuse to Sign _____

Unable to Sign (specify reason) _____

_____ _____
Signature of Person Documenting Refusal or Inability to Sign Date

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Consent for Treatment

Client Name_____ Date of Birth _____

I give full consent for myself, my child/adolescent or dependent due to legal guardianship to receive outpatient mental health services until I notify Carla J Wynn LCSW DCSW of any changes or until it is determined the treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for the individual stated above.

_____ _____

Authorized Signature Date

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Client Information Statement

The Texas Boards of Examiners of Social Workers and Marriage and Family Therapists were established by the legislature to protect the public. In fulfilling its mission, the Boards enacted rules governing the practice of social work and family therapy. These rules require that a therapist provide prospective clients with sufficient information about the therapeutic process so that the client can make an informed decision whether or not to enter therapy.

Attached to this Information Statement is a general information statement, Agreement for Services and the information regarding the procedures or psychotherapy in general and our office policies.

After reading the agreements, please ask about any part of the agreement that you do not understand.

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Information, Consent and Policies

I am honored that you have selected my practice for psychotherapeutic services. I will do my best to assist you in making this experience meaningful and fruitful. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I am a licensed psychotherapist who has practiced in The Woodlands since 1998. I am accredited by the state of Texas as a Licensed Masters Social Worker, Licensed Clinical Social Worker/Psychotherapist. I received a BSW from the University of Kansas and Texas Southern University, and an MSW from the University of Houston. My experiences include child, adolescent, adult, family psychotherapy; creation and implementation of intensive outpatient interventions addressing the individual, family and subsequent interactions with the environment, workshop presentations regarding dual diagnosis, bipolar disorder, anger management, chronic illness and reactive attachment disorder. Most recently, my research in the area of Pediatric Bipolarity and self-regulation was published in the Journal of Brief Therapy (2002).

I hold an abiding belief that no matter how difficult a person's circumstances may be it is possible to produce meaningful change. I view the therapeutic relationship as collaboration with my client on a unique journey towards self-enhancement, wellness and goal attainment. My theoretical basis takes into consideration the developmental stage of not only the individual but the family as well. In this effort, we explore the emotional and psychological demands of individuation, interpersonal and adaptive coping skill development. As a client you are in complete control and may end our professional relationship at any point. I will be supportive of that decision. Ultimately, my job is to work myself out of a job, so that you can feel self-assured to carry on without my intervention.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you arrange with me. It may be confusing and counter-productive for me to accept gifts or be invited to social gatherings. So please do not ask me to relate to you in any way other than in the professional context of our sessions. I want your sessions to be safe and secure as possible so that we concentrate exclusively on your concerns. You are best served by experiencing me in my professional role. If at any time, you are dissatisfied with my services, please let me know.

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Children can be joyful and energetic. However, I request that you obtain a sitter for children not receiving treatment so that our full attention can be devoted to your priorities.

I assure you that our work will be conducted in a conscientious manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results.

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Office Policies

1.____Initial:

Fees Schedule: All fees for services or co-pay amounts are due at the time of the appointment. For payment, please see the office staff prior to each appointment. Follow-up appointments will not be honored if your account is overdue. If an outstanding balance accrues, you will be billed on the first of the month and assessed a 2% finance charge, compounded monthly. There is a $20.00 rebilling fee for every statement sent out after the first billing. There is also a $35.00 fee for each check returned for insufficient funds. After 90 days with no payments or effort to arrange payment, accounts will be turned over to a collection agency and will impact your credit rating.

Session fee: $200 (50 minute duration) **After hour's session fee:** $300
Miscellaneous: Charges for other professional services are prorated on the basis of $ 200 per hour, 15 minute increments. These services include, but are not limited to, phone calls, insurance reports, third-party consultations, and correspondence. Off-site consultation is prorated at the rate of $200 per hour, "portal to portal", that is, for the time I am out of the office on your behalf.

____ Initial:
Legal testimony: Please be advised that **I do not provide consultation, evaluation or legal expert testimony in child custody, child visitation or molestation cases.** Similarly, my practice **does not** include expert testimonials. However, should my opinion be so ordered, fees will be charged at the rate of $650.00 per hour, portal to portal. This fee will apply as well to depositions or interrogatories. All fees of this nature are **payable in advance**.

2. **Office hours:** Tuesday through Thursday, 9:00am- 7:00pm. Any hours beyond stated office hours are considered as "after hours" and will be charged accordingly. After hours' time is generally reserved for family time and self-care.

3. ____Initial:
Cancellations: The scheduling of an appointment involves the reservation of time specifically for you. Therefore, **24 hours cancellation notice** is required so that there will be no charge to your account. **PLEASE CALL THE OFFICE TO CANCEL AN APPOINTMENT. EMAIL IS NOT MONITORED FOR CANCELLATIONS. The cancellation fee is the session fee.** If you are unable to meet this time schedule, but we are able to assign your appointment time to another client, you will not be charged. Due to the fact that your appointment is contracted time specifically set-aside for you, cancellations in advance will be appreciated.

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4. **Insurance:** Your health insurance policy is a contract between you and your insurance company. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company. Some insurance companies reimburse clients for services and some do not. Those that do usually require a standard amount be paid by you before reimbursement is allowed, and then usually a percentage of the fee is reimbursable. The client remains responsible for payment in full, including any portion not reimbursed by insurance. Please be aware that third-party payers require the provision of a diagnosis and supporting clinical data. We have no control over the confidentiality procedure of third parties once clinical information leaves this office. In all likelihood, a computer record will be generated. We will provide an insurance submittable receipt.

5. **Confidentiality:** All information disclosed within sessions is confidential and may be revealed only in certain situations. At times I may legally and/or ethically be required to share information about you without your consent. Such situations are, but are not limited to the following:

- Information released to other professionals involved in your treatment.
- If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to other parties.
- If you are determined to be in imminent danger of harming yourself or someone else unless protective measures are taken.
- If you disclose abuse or neglect of children, the elderly, or disabled person.
- In the instance of reasonable suspicion of child or elder abuse.
- If you disclose sexual misconduct by a therapist.
- To individuals, corporations or governmental agencies involved in paying or collecting fees for services (this includes insurance companies). *Please be advised that insurance reimbursement usually requires background information, including substance abuse, diagnostic criteria and treatment plan form completion. In addition, please note that most applications for health insurance include a release of information for medical records (this would include therapy/counseling records).*

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- In criminal court proceedings.
- In legal or regulatory actions against a professional.
- In proceedings in which a claim is made about one's physical, emotional or mental condition.
- When disclosure is relevant in any suit affecting the parent-child relationship. This includes divorce and child custody deliberations.
- Where otherwise legally required.

6. **Emergency services:** It is assumed that outpatient clients are self-responsible, autonomous, and not in need of day-to-day supervision. Outpatient clinicians cannot assume responsibilities for clients' day-to-day functioning, as can agencies or inpatient hospital settings. Nevertheless, in the event that an emergency occurs, leave a message 281-516-5745. I will respond to your call as promptly as possible. Routine calls will be returned during normal office hours.
If we are unable to respond quickly enough, please call 911 or your local emergency room.

Having read the policies described above, I agree to all professional policies, agree to meet all financial obligations, and agree that this contract replaces any earlier contracts. Additionally, I understand that there can be no absolute guarantee of cure in the practice of psychotherapy.

_____ _____

Signature **Date**

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Electronic Communications

Email

Please do not email me content related to your therapy sessions. Email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of the Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

___ Additionally, I also use email for administrative purposes. Please check here to give consent to email superbills and statements to your email address.

Friending/Texting/Messaging

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites (e.g. Facebook, LinkedIn) to contact me. I will not respond to messages via social networking sites. These sites are not secure and I do not read these messages in a timely fashion. If you need to contact me between sessions, the best way to do so is by phone. Direct email is second best for administrative issues; however, it is not best if you need to cancel an appointment within 24 hours. Please refer to the cancellation policy.

You are responsible for information security on your computer. If you decide to keep copies of our communication on your computer, it's up to you to keep that information secure. Unfortunately, I cannot guarantee the security of our emails as they travel between our computers. It is possible, though unlikely, to intercept emails in transit. If you are concerned about that possibility, please consider the option to encrypt our emails. Even if someone were to intercept an encrypted email, they would not be able to read the encoded message.

Teletherapy

Teletherapy is the use of electronic transmissions using interactive audio, video,or data communications. Existing confidentiality protections apply as noted in the HIPAA/PHI information document provided.

Unless we explicitly agree otherwise, our Teletherapy exchange is confidential. Any personal information you choose to share with me will be held in the strictest confidence. The risks involved

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with Teletherapy include the potential release of private information due to the complexities and abnormalities involved with the Internet. Viruses, Trojans, and other involuntary intrusions have the ability to grab and release information you may desire to keep private. Furthermore, there is the risk of being overheard by anyone near you if you do not place yourself in a private area.

While Teletherapy is a great way to get help with many of life's problems, overwhelming or potentially dangerous challenges are best met with a face-to-face professional support. You understand that our Teletherapy is neither a universal substitute nor the same as face-to-face psychotherapy treatment. You accept the distinctions made using Teletherapy vs. face-to-face psychotherapy. In particular, you accept that Teletherapy does not provide emergency services.

It is YOUR responsibility to create an environment on your end of the Teletherapy transmission that is not subject to unexpected or unauthorized intrusion of your personal information. It is my responsibility for me, the therapist, to do the same on my end.

If you have questions or concerns about any of these policies and procedures or regarding our potential interactions via electronic communication, do bring them to my attention so that we can discuss them.

There are no other explicit or implied commitments in our Telecommunication relationship.

Patient Signature:_____ Date: _____

Patient Printed Name: _____

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PSYCHOSOCIAL HISTORY

Date _____ Date of Birth _____

Name of Patient_____

Presenting Problems:

____Recent life transition
____Depression, isolation, withdrawal
____Suicide gesture, attempt or ideation
____Homicidal ideation
____Self-abusive behavior
____Abuse (physical, emotional, sexual)
____History of traumatic life events (in addition to the previous)
____Neglect, abandonment
____Marginal to low IQ
____Difficulty at school or work
____Difficulty with authority
____Commits unlawful acts
____Under socialized (difficulty making friends)
____Anger outbursts/rage
____Run away from home or placement
____Impulse control problems
____Low self-esteem
____Physically aggressive
____Destruction of property
____Sexual dysfunction
____Does not feel guilty about wrongdoing
____Paranoid thoughts, delusions
____Hallucinations (auditory, visual, tactile)
____Gender identity problems
____Excessive worry, racing thoughts, obsessions
____Compulsive behavior
____Substance abuse

Have you had any **treatment** for these problems before today? Y N

If yes, when? Where? Who was your doctor or therapist?

_____

_____

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History of psychiatric hospitalizations

Date_____Location_____Outcome_____

Date_____Location_____Outcome_____

Date_____Location_____Outcome_____

Current Medications

Family past psychiatric history

Family medical history

Personal past medical history

Drug and Alcohol Abuse

Any **personal / family** history of drug and/or alcohol usage? Please list and describe.

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Family History (include spouse, significant other, children, parents, step families, adoption history, etc.)

Name	Relationship	Age	Living where?

Marital status of patient

Married_____ Divorced_____ Separated ____ How long___ How long ago ____

Widow/widower_____How long ago _____

Other _____

Other significant adults or children in patient's life (Please include type of relationship-e.g. supportive, conflictual, etc.)

_____

_____

_____

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Traumatizing Life Events

Have you experienced any history of significant abuse (physical, emotional or sexual)?

Please briefly describe _____

_____

_____

_____

Any history of **significant life events** such as deaths, separation from parent(s), frequent moves, terminal illnesses in the family or close friendship?

_____

_____

_____

_____

Relationship issues

Are you currently dating?_____at what age was your first date? _____

Are you sexually active?_____at what age was your first sexual encounter? _____

Would you consider yourself to be heterosexual / homosexual / bi-sexual _____

_____

Would you describe yourself as timid or as social (easily makes friends and participates in social functions) _____

Cultural Influences

With what ethnic/cultural/religious groups do you personally identify? _____

With what ethnic/cultural group does your family most identify? _____

Describe any beliefs that may impact therapy: _____

_____

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Educational History

Highest degree earned_____

Current School attending_____Grade_____

Average grade performance _____

Overall motivation to attend school _____

Extracurricular activities_____

Employment History

Present employment status-where-how long? _____

Positive/negative aspects of current position _____

_____

If on leave of absence or disability, will you return to present job? _____

_____

Special interests/hobbies/skills

_____

_____

Desired Treatment Goal (s)

_____

_____

_____

Additional Comments _____

_____

_____ _____

Signature **Date**