Ruth E. Bedsole, M.A., L.P.C., L.M.F.T.
Texas Licenses LPC 04491, LMFT 4883
12946 Dairy Ashford Drive, Suite 260, Sugar Land, Texas 77478,
Phone: 281-242-2334 Fax: 281-242-2909

Consent for Evaluation/Treatment

Client's Name: _____ Date of Birth: _____

I _____, hereby give full consent for myself to receive services of Ruth E. Bedsole until I notify her or she determines services are no longer appropriate or will no longer be provided. I understand my first session with Ms. Bedsole is a consultation only. This consultation is for an evaluation of my (or my child's) mental health. It may take more than one session to complete the evaluation. I understand formal treatment is not initiated until Ms. Bedsole and I agree to do so.

I authorize Ruth E. Bedsole to carry out the psychological assessments and treatment which are advisable during the course of my psychotherapy. I understand that while the assessment and treatment is designed to be helpful and beneficial, it may at times be difficult and uncomfortable. There is an expectation that I (or my child) will benefit from the assessment, but there is no guarantee this will occur. I also understand that the nature of psychotherapeutic treatment includes the possibility that symptoms may worsen before improving, and that there is no guarantee of a cure.

CONFIDENTIALITY

I understand Ms. Bedsole regards the information I share with her as most confidential, and that she honors my right to privacy. I understand she adheres to what she believes to be a much more stringent set of confidentiality guidelines than those provided by the State of Texas or the federal department of Health and Human Services. Specifically, I understand Ms. Bedsole is required to disclose confidential information without my consent under certain circumstances that include, but are not limited to the situations listed below. Should disclosure be necessary, Ms. Bedsole will make every reasonable effort to inform me of the disclosure.

1) If I am evaluated to be a danger to myself or others;
2) If I am a minor, elderly, or disabled person and Ms. Bedsole believes that I am the victim of abuse or if I divulge information about such abuse;
3) If I divulge information which would cause Ms. Bedsole to reasonably believe that I have abused or neglected a minor, an elderly or disabled person, or a member of another protected class;
4) If I file a suit against Ms. Bedsole for malpractice;
5) If a court order, other legal proceedings, or statute requires disclosure;
6) If the patient is a minor, parents have access to medical records unless limited by court order;
7) If Ms. Bedsole is required to report certain professional ethical situations she will abide by Texas laws;
8) I further acknowledge that a third party payer may have limited access to otherwise confidential information.

If the course of therapy reveals any intent to harm either myself or others, I acknowledge Ruth E. Bedsole's legal and moral duty to prevent me from bringing this harm about. I specifically give my irrevocable permission to warn those parties she feels may be harmed. If I reveal an intent to harm myself, Ruth E. Bedsole has my permission, also irrevocable, to prevent me from accomplishing my intent.

RECORDS

I understand it is stated law that mental health professionals maintain a record of the treatment given to me. This record will contain the information that will allow Ruth E. Bedsole to chart the course of therapy. She will use it only for that purpose. It is her intent that no one will ever see what is contained in the file. I understand I

may get a copy of the file only by providing her with a signed release of information request. Ruth E. Bedsole may provide me with a synopsis of the course of treatment and outcome in lieu of the actual record. I agree I will pay in advance for either the copying cost of the actual record or the time required for the preparation of the treatment summary. This included providing copies or reports to any court or legal representative or designate. In the event of your death, these requirements will be binding on any heirs, successors or executor(s).

If the therapy sessions contain more than one patient, I agree that no one person may get the complete treatment file. I agree Ruth E. Bedsole, may synopsize the course of each individual's treatment as opposed to providing a copy of what notes may have been made during any therapy session.

If I have been referred to this practice by a managed care or insurance company, or I plan to request Ruth E. Bedsole, file for reimbursement with a managed care or insurance company, I am aware that she may have to waive my right to confidentiality as it pertains to in the managed care or insurance company. If she is an approved provider, she may have to share all the information I provide with this organization. I understand Ruth E. Bedsole, will do so as required to get me all the treatment that is appropriate. I am aware that the organization is not bound by her ethical and legal requirements on maintaining the confidentiality my treatment may require. Once these records are in the possession of the managed care or insurance company, Ruth E. Bedsole, cannot guarantee their continued confidentiality.

THERAPIST'S INCAPACITY OR DEATH: In the event your therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of your files and records. By signing this form, you give consent to allow another licensed mental health professional selected by your therapist to take possession of your records and provide copies upon your request, or to deliver them to a therapist of your choice.

TERMINATION OF TREATMENT

I understand the length of time required for therapy will be determined by my personal situation. I understand Ruth E. Bedsole, will do her best to fulfill my therapeutic needs and to provide me with her best professional care. For my part, I agree to participate in the process to the best of my ability. It is intended that when my needs are met, to the extent that they can be, we will terminate our relationship.

I understand for my part, I may terminate treatment at any time. This may be accomplished in any one of several ways. These include, but are not limited to, putting it in writing, informing me verbally, failing to maintain my appointment schedule without proper notification, or failure to follow treatment recommendations. I understand Ruth E. Bedsole, will respect my wishes to terminate treatment. I also understand the method I choose to accomplish termination will impact any decision to resume a therapeutic relationship with her.

My signature on this consent form verifies I have had the opportunity to ask questions regarding procedures, policies, and therapeutic techniques, that my questions were answered to my satisfaction by Ruth E. Bedsole, and that I voluntarily give my consent for treatment. I understand that I have the right to withdraw my consent for treatment at any time.

_____ _____

Client's Signature Date

_____

Printed Name of Client

_____ _____

Signature of Witness Date

_____

Printed Name of Witness

RUTH E. BEDSOLE, L.P.C., L.M.F.T.

12946 Dairy Ashford, Suite 260
Sugar Land, TX 77478
Ph: 281-242-2334 / Fax: 281-242-2909

PAYMENT AGREEMENT

Self Pay/ Out of Network

Initial Evaluation	$160	per 60 minutes session
Individual Psychotherapy	$130	50 minutes session
Couple/Family Psychotherapy	$150	50 minutes session
Legal Fees	$240	per hour, $60 per 15 minutes
Includes phone time, report/letter writing, travel		
Copying Records	$1.00	per page

In-Network Benefits:

Your insurance has quoted us the following information on this date: _____. However, information reported to us is not a guarantee of benefits, and benefits are subject to change at any time. We will work under the assumption that the following terms are applicable per verification of your benefits. Should we be informed of insurance nonpayment of services or changes in the information below, you will be notified as soon as possible:

Deductible: _____

Co-Payment/session: _____

Authorization #:_____

Submission of Claims:

Please be advised that our office will make 2 good faith efforts to collect from your insurance company. If unsuccessful, patient will be required to provide payment in full and documentation of unsuccessful efforts will be provided.

Missed Appointments: 24 hours notice of cancellation is requested

Less than 24 hours or no notice of cancellation: $75 fee per late or no notice cancellation
After 3rd missed appointment: $100 fee per late or no notice cancellation

I understand and agree to all of the above information.

Name of Patient: _____
(please print) *Last* *First* *Middle*

Signature:_____ **Date:**_____

PERSONAL HISTORY QUESTIONNAIRE

It is often helpful in therapy for me to have a general understanding of various aspects of your life. Please take a few moments to complete this questionnaire. Feel free to write on the back of the page.

Name: _____ **Date of Birth:** _____

Address: _____

Home Phone: _____ **Can I leave a message on this line? Yes No**

Work Phone: _____ **Can I leave a message on this line? Yes No**

Cell Phone: _____ **Can I leave a message on this line? Yes No**

How did you find out about me? _____

EDUCATION/EMPLOYMENT BACKGROUND

Highest level of education completed: _____

What is your current employment status? Ex. Are you staying home raising children? Working part time? Working full time? Have you changed jobs recently? Are you a student? Etc.

_____

_____

Are you content with your current employment?

_____

FAMILY

Please list family members who live in the home with you and their ages.

_____ _____

_____ _____

_____ _____

_____ _____

Are there any children who live elsewhere? Please list their names, ages, and reason for moving out.

_____

_____

_____

Does either parent travel frequently? How often? _____

_____

Has there been a divorce in the family? If so, when? If there are children, what are the custody arrangements?

_____

_____

Are there any other family members who are very actively involved in your family life? If so, who?

_____

STRESSORS

Have you experienced any stressful events in the last year? Please check the following.

- ☐ Death in the family
- ☐ Death of a close friend
- ☐ Serious illness or injury, your own
- ☐ Serious illness or injury, a loved one
- ☐ Family fighting
- ☐ Marital problems
- ☐ Divorce or separation
- ☐ Marital reconciliation
- ☐ Problems with child rearing
- ☐ Move to a new home
- ☐ Son or daughter leave home
- ☐ Conflict with in-laws
- ☐ Change in job - new position, new company, laid off, retired, quit
- ☐ Change in financial status, either more or less money
- ☐ Change in daily responsibilities
- ☐ Change in social network
- ☐ New marriage in the family
- ☐ Outstanding personal achievements
- ☐ Other: _____

MEDICAL HISTORY

Do you have any of the following medical problems?

Current	Past		Current	Past	
☐	☐	Heart Problems	■	☐	Head Injury
☐	☐	Digestive Problems	■	☐	Surgeries
☐	☐	Hypothyroidism	☐	☐	Tics
☐	☐	Hyperthyroidism	☐	☐	High Blood Pressure
☐	☐	Diabetes, Type I	☐	☐	Reproductive Problems
☐	☐	Diabetes, Type II	☐	☐	PMS symptoms
☐	☐	Overweight	☐	☐	Muscle tension
☐	☐	Underweight	☐	☐	Headaches
☐	☐	Back or neck pain	☐	☐	Cancer

If you checked any of the boxes on the previous page, please describe the problem.

_____

_____

Are you currently taking any medications? If so, please list. _____

_____

Are there any other medical problems not listed above that you experience? _____

_____

RECREATION

How do you spend your "free time"?_____

_____

Please check the following activities that you engaged in the last month.

- ☐ Exercise, how frequently?_____
- ☐ Out with friends, how frequently?_____
- ☐ Out with spouse, how frequently? _____
- ☐ Relax, how frequently? _____
- ☐ Took time to yourself, how frequently? _____
- ☐ Enjoyed something

MENTAL HEALTH HISTORY

Have you sought psychotherapy before? If so, what were the circumstances?

_____

_____

_____

Did you find therapy helpful? _____

Are you currently, or have you ever, taken any medications to help with any mental health problems? If so, please list.

_____

_____

Did you (or do you) find the medication helpful?

_____

What do you hope to gain out of therapy? What changes do you hope to make?_____

_____

Have you or any of your family members struggled with any of the following problems?

	Myself, current	Myself, past	Parent	Sibling	Child	Spouse
Depression, sadness						
Anxiety / Excessive Worries						
Panic Attacks						
Obsessions and/or Compulsions						
Suicidal thoughts						
Attempted Suicide						
Learning Disabilities						
Attention Deficit/Hyperactivity						
Problems with Anger						
Problems with Assertiveness						
Oppositionality/Defiance						
Schizophrenia or Psychosis						
Nervous Breakdown						
Heavy Alcohol Use						
Drug Use/Abuse						
Eating Disorder						
Abused in any way						
Other:						

REASON FOR SEEKING PSYCHOTHERAPY

What problems are you struggling with that have brought you here today? _____

_____

_____

ANYTHING ELSE?

Is there anything else you would like to make sure I know? _____

Ruth E. Bedsole, MA, LPC, LMFT, P.C.

NOTICE OF PRIVACY PRACTICES

IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS HOW YOU MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY AND SIGN THE ACKNOWLEDGEMENT OF RECEIPT.

Protecting Your Personal and Health Information

This notice will explain how we handle your medical/mental health information. Applicable federal and state laws require us to maintain the privacy of clients' personal and health information. In this Notice, your personal or protected health information is referred to as "health information" or "PHI" and includes information regarding your health care and treatment with identifiable factors, such as your name, age, address, income or other financial information. Because state and federal laws, combined with our professional ethics, are very complicated, some parts of this notice are very detailed and may seem difficult to understand. Please know Ruth E. Bedsole, MA, LPC, LMFT, PC is committed to protecting the privacy of your health and personal information and is available to answer any questions you may have.

How We Protect Your Health Information

Ruth E. Bedsole, MA, LPC, LMFT, P.C. protects your health information by treating all of your health information that she collects as confidential (for exceptions to confidentiality see Consent for Treatment), by training all staff in federal and state confidentiality policies and practices per HIPAA, by restricting access to your health information only to those office staff that needs to know your health information in order to provide her services to you, and by maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information.

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

Ruth E. Bedsole, MA, LPC, LMFT, P.C. may use or disclose your protected health information for treatment, payment, and health care operations purposes if you have given consent to receive evaluation or treatment services.

Clarification of terms:
PHI- information in your health record that could identify you.
Treatment, Payment, and Health Care Operations
Treatment- when office provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when our office consults with another health care provider, such as your family physician.
Payment- when you provide reimbursement for the services you receive in the office. An example of payment would be when our office discloses 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 our office. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, case management and care coordination, and conducting training and educational programs or accreditation activities.
Use – Activities within the office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
Disclosure – Activities outside of the office, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

Ruth E. Bedsole, MA, LPC, LMFT, PC and any administrators of her may use or disclose PHI for purposes outside Treatment, Payment, or Health Care Operations when your authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when the office is asked for information for purposes outside of Treatment, Payment, or Health Care Operations, we will obtain an authorization from you before releasing this information.
Specific authorization is also obtained before releasing your psychotherapy notes. Psychotherapy notes are notes made about treatment and are given a greater degree of protection than PHI.
You may revoke all such authorizations at any time, provided each revocation is in writing. After that time, we will not use or disclose your information for the purposes originally agreed upon. However, we cannot take back any information already disclosed with your permission or that we had used in our office.

Uses and Disclosures Not Requiring Consent or Authorization

The laws lets Ruth E. Bedsole, MA, LPC, LMFT, PC use or disclose PHI without your consent or authorization in some cases. Here are some examples of when this might occur:
When Required by Law - Suspected child abuse must be reported. Also, if you are involved in a lawsuit or legal proceeding and the provider receives a subpoena, discovery request, or other lawful process, some of your PHI may have to be released. This will occur only after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information being requested. Finally, some information has to be disclosed to governmental agencies, which check on providers to see that privacy laws are being obeyed.
For Law Enforcement Purposes – Information may be released if your provider is asked to do so by a law enforcement official to investigate a crime or criminal.
For Public Health Activities – Some of your PHI might be disclosed to agencies which investigate diseases or injuries.

Relating to Decedents – PHI might be disclosed to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.
For Specific Government Functions – PHI of military personnel and veterans may be disclosed to government benefit programs relating to eligibility and enrollment. PHI may also be disclosed to Workers Compensation and Disability Programs, to correctional facilities if you are an inmate, and for national security reasons.
To Prevent a Serious Threat to Health or Safety – If your provider believes that there is a serious threat to your health or safety or that of another person or the public, the provider can disclose some of your PHI. This disclosure will only be provided to persons who can prevent the danger.
Therapist's Incapacity or Death – In the event that your provider becomes incapacitated or dies, it will become necessary for another therapist to take possession of your files and records.

Patient Rights and Provider's Duties

Patient Rights:
Rights to Request Restrictions – You have the right to request that your provider limits what is told to people involved in your care or the payment of your care, such as family members and friends. Ruth E. Bedsole, MA, LPC, LMFT, PC may not be able to accept your request; however, if accepted she will uphold it except in case of emergency or if it is against the law.
Right to Receive Confidential Communications by Alternative Means/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 being seen at the office. On your request, communications will be sent to an alternate address.)
Right to Inspect and Copy – You have the right to inspect and/or obtain a copy of your records. A reasonable fee may be charged for copying. Access to your records may be limited or denied under certain circumstances, but in most cases you have a right to request a review of that decision. 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 in writing an amendment of your health information for as long as PHI records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.
Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.
Electronic vs. Paper – If you received this notice electronically (e.g., accessing a website) you have the right to obtain a paper copy of the notice from the office upon request.

Duties of Ruth E. Bedsole, MA, LPC, LMFT, PC:
Provider is required by law to maintain the privacy of PHI and to provide you with this notice of legal duties and privacy practices. Ruth E. Bedsole, MA, LPC, LMFT, PC reserves the right to change the privacy policies and practices and terms of this Notice at any time, as permitted by applicable law. She reserves the right to make the changes in privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Unless we notify you of such changes, however, the office is required to abide by the terms currently in effect.

Questions and Complaints

For questions regarding this Notice of our Privacy Practices, or if you are concerned that your privacy rights may have been violated, please contact Ruth E. Bedsole, MA, LPC, LMFT, PC. You may also make a written complaint to the US Department of Health and Human Services, whose address can be provided upon request. If you choose to make a complaint with the US Department of Health and Human Services, or with me, I will not retaliate in any way.

Ruth E. Bedsole, MA, LPC, LMFT, PC
12946 Dairy Ashford, Suite 260
Sugar Land, Texas 77478
281-242-2595

Ruth E. Bedsole, MA, LPC, LMFT, P.C.

CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

In my notice of Privacy Practices, I provide you with information about I can use or disclose your personal and health information. As described in my Notice of Privacy Practices, I request your consent for use or disclosure of mental health and medical information to carry out treatment, payment, or health care operations. You have a right to review my Notice of Privacy Practices before signing this Consent form.

By signing this Consent form, you: (1) Acknowledge that a copy of the Notice of Privacy Practices has been provided to you; and (2) Consent to our use and disclosure of your health information for treatment, payment, or health care operations, as described in the Notice of Privacy Practices.

You have the right to revoke this Consent in writing any time, except where we have already used or disclosed your health information in reliance upon this Consent.

_____

Patient's Name (Printed)

_____ _____

Signature of Parent or Legal Representative Date

_____

Printed Name of Parent or Legal Representative