Leslie Bley, LPC-S

4220 Monterey Oaks Blvd Austin, TX 78749
Phone: 314-497-7681
lesliebleylpc@gmail.com
www.lesliebleycounseling.com

CLIENT INFORMATION

Name _____ Phone _____

Address _____ City _____

State _____ Zip _____ Birth Date _____/_____/_____ M / F Or preferred pronoun? _____

May I leave text & voice msgs with the phone number listed? Please initial _____ Yes _____No

Single Married Widowed Separated Divorced # _____ Children # _____ Years married

Medications currently taking _____

_____

Preferred email address: _____

Employer _____ Occupation _____

Name and Phone # for Emergency _____

Would you like reminder emails before sessions? _____ Yes _____ No

Do you plan to submit receipts for services to your insurance carrier? _____ Yes _____ No

In a few words, what has brought you to counseling? _____

_____

_____

_____

Which format do you prefer: _____ In Office _____Telehealth _____ No preference

If you are comfortable sharing, is there a religion you subscribe to? _____

If you are a church member, what is the name of your church? _____

COMMUNICATION/PAYMENT CONSENT [please initial to consent]

_____ I grant permission to send and receive communication from my therapist at my preferred email.

_____ I grant permission to conduct counseling sessions via web-based applications.

_____ I recognize that email and other forms of Internet/web-based communication are not a secure/ confidential means to transmit data. By initialing here, I voluntarily waive my rights provided by the HIPAA law, and any other federal or state laws regarding confidentiality and the transmission of information via the Internet. I voluntarily give my permission and will not hold Leslie Bley, LPC-S legally responsible for the transmission of this data.

_____ I agree that I am not currently in a legal case and will not call on my counselor for any court proceedings.

_____ I give permission to Leslie Bley to allow faith-based counsel in our sessions if that is something I desire as a part of our therapeutic relationship.

_____ I understand that Leslie Bley has a Professional Will in place and give permission to her Executors to contact me and have access to my mental health records if that becomes necessary.

_____ I give permission to Leslie Bley to use general information about our therapeutic work for private consultation with her professional mentors for the well-being of our work together.

_____ If a credit/debit card is preferred for payment, I authorize Leslie Bley to have the card information on file and charge per service.

Card #_____

Exp _____ CVV _____ Zip _____ Name _____

APPOINTMENTS & FEES

Sessions; including In-person, Telehealth, and by Phone are typically 50 minutes. My session rate is $140 and payment is expected per session. 75 minute sessions are $200. Cancellations under 24 hours before session and/or missed appointments (not due to emergencies) may be charged a $75 fee.

Consent to Treatment and Recipient's Rights

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above to receive treatment by Leslie Bley, LPC-S. I understand that the therapy may be discontinued at any time by either party, however, it is encouraged that this decision be discussed with the treating psychotherapist prior to discharge.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the Counselor is protected by Federal and/or State law and regulations. Generally, the Counselor may not say to a person outside the Center that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Counselor's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original.

I consent to treatment and agree to abide by the above stated policies and agreements with Leslie Bley, LPC-S.

_____ _____

Signature of Client/Legal Guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

Leslie Bley, LPC-S

Notice of Privacy Practices

Our Commitment to you and your privacy

This notice describes how information about you may be used and disclosed and how you can get access to it. HIPAA stands for the Health Insurance Portability and Accountability Act and was passed because of concerns in an age of electronic records. It is important to us you understand our policies and your rights to safeguard your protected health information (PHI). Some of this information is duplicated on the Standards and Policies.

Uses and Disclosures

We may use or disclose your protected health information (PHI) for treatment, payment, and health care purposes with your consent.

- PHI: information in your health records that could identify you
- Treatment: medical or mental health care provided to you by a physician or therapist
- Payment: to obtain payment for services we provide to you
- Health Care Operations: include quality assessment, business audits, administrative, case management and care coordination
- Use: activities within our practice such as examining and analyzing information that identifies you
- Disclosure: activities outside our practice such as releasing, transferring, or providing access to information about you to other parties

Use of Email

Email is not a preferred type of communication but if you choose to email, your information is not guaranteed to be protected. Your counselor most likely will not respond to any emails until in person within your scheduled session. Emails may contain PHI and email does not meet the necessary security requirements used to protect confidentiality. Email is NOT for emergencies.

Uses and Disclosures Requiring Authorization/Release

We may use or disclose your PHI when your authorization and signed release is obtained for these specific disclosures. Psychotherapy notes have a greater legal protection than your PHI and will not be released without your consent. As a client you may revoke all authorizations at any time, provided each revocation is in writing. You may not revoke authorization if the authorization has already been obtained and acted on or if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest under the policy.

Uses and Disclosures with neither Consent Nor Authorization

We may use or disclose your PHI without your consent or authorization as required by law in the following circumstances:

- Child abuse: if we have cause to believe a child has been or may be abused, neglected, we are required by law to report it within 48 hours to the proper authorities
- Elderly or Disabled Person Abuse: if we have cause to believe that an elderly or disabled person has been or may be abused, neglected, or exploited, we are required to report it to the proper authorities
- Health Oversight: if a complaint is filed against us with the State Board of Examiners, they have the authority to subpoena confidential mental health information that is relevant to the 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 and will not be released without written authorization. This does not apply when you are being evaluated for a third party or where the evaluation is court ordered.
- Serious Threat to Health or Safety: if we determine there is a probability of physical injury to yourself or others, or probability of such, we may disclose relevant confidential mental health information to medical or law enforcement personnel.

Clients Rights and Responsibilities

- You agree to responsibly participate actively in the process of therapy both in sessions and between sessions, and you also agree to be honest with your therapist
- You agree to arrive on time for sessions and pay for services received

- You agree to notify your counselor if you become unable to attend sessions and if you do not cancel within less than 24 hours, you agree to possibly pay a half charge for the session
- You have the right to request restrictions on certain uses and disclosures of protected health information. However we are not required to agree to a requested restriction.
- You have the right to request and receive confidential communications of PHI by alternative means and at an alternate location (i.e. bills sent to an alternative address).
- You have the right to inspect a copy of your PHI. Psychotherapy notes that are kept separate from PHI are protected.
- You have the right to request an amendment of PHI for as long as the PHI is maintained in your record. The request may be denied but the details will be discussed.
- You generally have the right to request an accounting of disclosures of PHI for which you have neither provided consent nor authorization.
- You have the right to obtain a paper copy of this notice.

Therapists 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 are required by law and state board code of ethics to break confidentiality if any of the above listed circumstances occur.
- We reserve the right to change the privacy policies and practices described in this document after notification.
- If revisions to policies and procedures occur, you will be notified and provided with a copy.
- Most therapists at Streams are not providers of insurance but will provide a needed diagnosis code for you to file with your insurance. Any diagnosis will become part of your permanent record.
- We will take care to practice within our individual level of competence and licensure.
- We will discuss the how's and why's of any suggested interventions within the therapy process.
- We will refer you to other professionals at any time you request.

Complaints

We encourage you to bring your concerns directly to your therapist or a supervisor on site. If you feel you are not getting adequate responses from direct interactions, you may file a complaint against a Licensed Professional Counselor by contacting the Texas Behavioral Health Executive Council at: *333 Guadalupe St., Ste. 3-900 Austin, Texas 78701 Tel. (512) 305-7700 1-800-821-3205 24-hour, toll-free complaint system.*

Acknowledgement of Receipt of Privacy Policies Notice

□ I have received a copy of the privacy policies documented above

_____ _____

Client—Print Name Client (if more than one)—Print Name

_____ _____

Client—Signature Client (if more than one)—Signature

_____

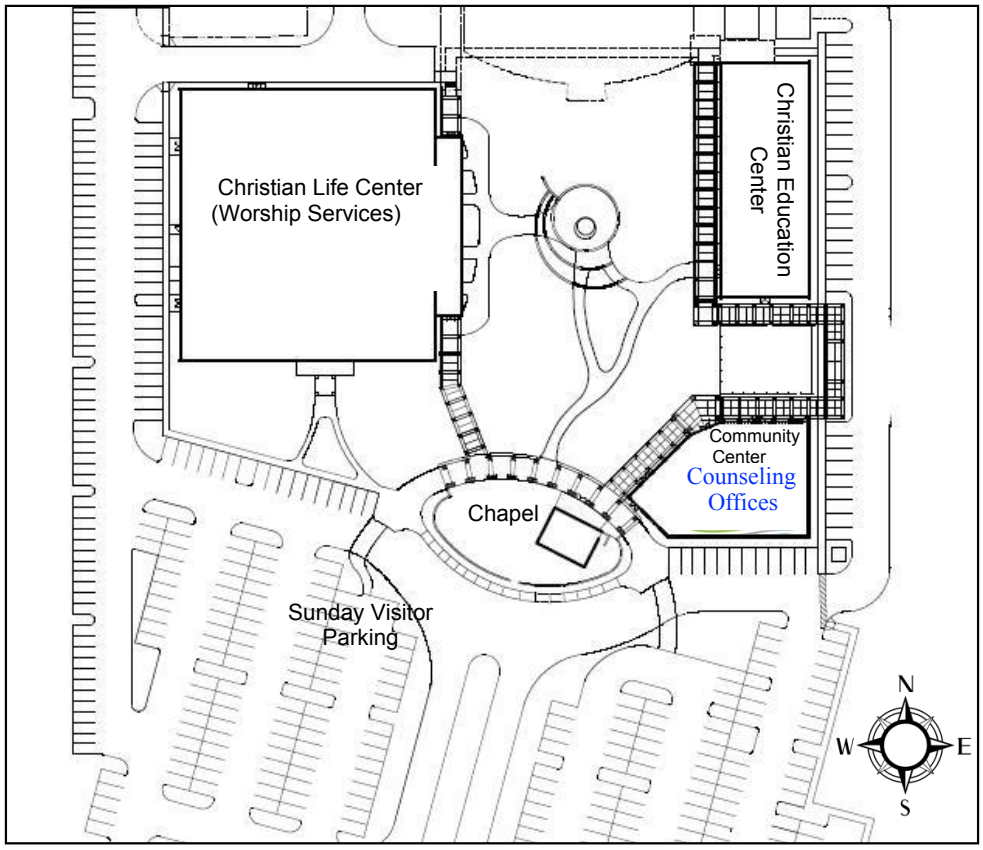
Date

Leslie Bley, LPC-S

STREAMS COUNSELING CENTER AT AUSTIN OAKS CHURCH

4220 MONTEREY OAKS BLVD
AUSTIN, TX, 78745
512-891-1600 (AOC receptionist)

When you arrive, please come to the 3rd floor of the Community Center. There is a waiting area near the counseling offices to your right after getting off the elevator. I will come greet you at the time of our appointment.



To MOPAC (Loop 1) Access Road

To Monterey Oaks Boulevard