**New Client Forms**

**Please initial each item**

\_\_\_\_\_\_\_\_\_\_ I understand that Dane Osborne does not provide 24-hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1 or go to an emergency room for assistance.

\_\_\_\_\_\_\_\_\_\_ I understand that during the time that we work together, we will meet weekly for approximately 50 minutes. While our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one.

\_\_\_\_\_\_\_\_\_\_ I understand our contact will be limited to counseling sessions and phone contact. If a phone consultation is necessary you may call Dane at 682-253-4301. Applicable fees for phone consultation services exceeding 15 minutes will apply.

\_\_\_\_\_\_\_\_\_ I understand that, at any time, I may initiate a discussion of possible positive or negative effects of entering into the counseling relationship and those specific results are not guaranteed although benefits are expected from counseling.

\_\_\_\_\_\_\_\_\_ I understand that counseling can improve as well as upset the equilibrium in any person or family. Counseling is a personal exploration and may lead to changes in my life, perspectives, and decisions. These changes could be temporarily distressing.

\_\_\_\_\_\_\_\_\_\_ I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship. *After discussing readiness to end services, client is requested to meet for an additional two sessions to ensure proper termination.*

\_\_\_\_\_\_\_\_\_\_ If at any time I am dissatisfied with Dane Osborne’s services as a therapist, I have a right to let him know. If I do not feel that Dane may resolve my complaint, I may file a formal complaint though contact with the Texas Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

\_\_\_\_\_\_\_\_\_\_ I understand that our paths may cross in social situations but that our therapeutic relationship comes first. In order to protect my confidentiality Dane will not initiate a greeting.

\_\_\_\_\_\_\_\_\_\_ Should Dane believe a referral is necessary, he will provide me with said referrals.

**Financial**

\_\_\_\_\_\_\_\_\_ I understand that the rate for all therapy sessions is $70. These fees are for a 50-minute session. Checks or credit cards are acceptable forms of payment.

\_\_\_\_\_\_\_\_\_ I understand that all fees for counseling are due after each session. Appointment for additional sessions cannot be made until my balance is paid in full or other payment arrangements have been made.

\_\_\_\_\_\_\_\_\_ I understand that if a check is returned, a processing fee of $25 will be assessed to my account. Additionally, I will need to make a cash or money order payment for the returned check and $25 processing fee. After a returned check, the office requires credit card or cash payment for future appointments.

\_\_\_\_\_\_\_\_\_ I understand that I am responsible for any appointments that are not cancelled at least 24 hours prior to my appointment time, with the exception of an emergency. I understand that if I do not cancel my appointment 24 hours ahead of time, I will be charged the full session fee.

\_\_\_\_\_\_\_\_\_ If, at any time, therapist feels he can no longer be of assistance, benefit the client, or if he feels unable to assist client in reaching their goals, he will inform the client, provide referrals, and create a transition plan with the client. If client refuses the referrals, therapist will terminate counseling with the client.

**Confidentiality**

\_\_\_\_\_\_\_\_\_ I understand that while most of our communication is confidential there are, however, circumstances when disclosure can occur without my prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

• You are a danger to self or someone else.

• In situations of suspected child, spouse, or elder abuse, it is the legal duty of the mental health provider to notify medical, legal, or other authorities.

• You disclose sexual contact with another mental health professional.

• If you or your child is involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.

• Dane Osborne is ordered by a court to disclose information.

• You direct Dane Osborne in writing to release your records.

• Dane Osborne is otherwise required by law to disclose information.

\_\_\_\_\_\_\_\_\_ I understand that should Dane Osborne become incapacitated or deceased, his files will become the property of the designee. Currently that designee is Rozan Christian with Rozan Christian Counseling.

\_\_\_\_\_\_\_\_\_ I understand that should an emergency occur with Dane Osborne, I may be contacted on Dane’s behalf.

**Parents**

\_\_\_\_\_\_\_\_\_ I understand that if I am seeking services that involve another person, such as a minor child, that Dane Osborne will not break confidentiality of that client unless there is a safety concern. Dane will maintain confidentiality at all times as outlined by the Texas Law and Ethics Code for Licensed Professional Counselors.

\_\_\_\_\_\_\_\_\_ I will respect the therapeutic boundaries and will not attempt to gain information about the content of sessions by contacting Dane or asking my child.

\_\_\_\_\_\_\_\_\_ I understand that parental attitude toward the therapeutic process greatly contributes to positive outcomes in my child’s therapy.

**Technology Usage**

\_\_\_\_\_\_\_\_\_ I understand that personal content sent via text or email is not secure and can potentially be compromised.

\_\_\_\_\_\_\_\_\_ I understand that Dane Osborne will not be held liable for personal information that I choose to send via email or text should confidentiality be compromised.

\_\_\_\_\_\_\_\_\_ I understand that emails and texts should only be used for scheduling or exchanging information pertaining to appointments. My therapist will not respond to personal content sent via email or text. Should I need to speak with her between sessions with topics other than scheduling, I will do so by telephone.

\_\_\_\_\_\_\_\_\_ I understand that this is a professional relationship and therefore, invitations to Facebook, Instagram, Snap Chat, LinkedIn, or any other social media site will not be accepted.

**Telehealth Sessions**

I understand that Dane Osborne offers Telehealth counseling sessions and I wish to engage in Telehealth sessions.

I understand that a Telehealth session has potential benefits, including easier access to care and convenience of meeting from a location of my choosing.

I understand there are potential risks associated with technology, including interruptions, unauthorized access, and technical difficulties, although Dane Osborne is working diligently to minimize these occurrences. I understand Dane Osborne may discontinue Telehealth sessions if it determines another level of care may be more appropriate. I understand that Dane will make me aware of any technology breaches and reasons for referral.

I understand I will have the opportunity to speak with a Dane to address any questions or concerns I have regarding Telehealth counseling.

I understand Dane Osborne it NOT an emergency or crisis center. In the event of an emergency, I will call 911.

To maintain confidentiality, I will not share my Telehealth link with anyone unauthorized to attend the appointment.

By E-signing or signing this form, I certify I have read or had this form read to me, and that I understand the risks and benefits of Telehealth and agree to participate in Telehealth counseling with Dane Osborne

Client E-Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor E-Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Status Information**

Are you or your child currently thinking about suicide or harming yourself in any way?

☐ yes ☐ no

Have you or your child had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way?

☐ yes ☐ no

Are you or your child having any thoughts about harming anyone else in any way?

☐ yes ☐ no

**Statement of Understanding**

I have read the above and understand the nature of service providers and the Limits of Confidentiality outlined above and solemnly swear that all of the above information is true to the best of my knowledge.

Client Signature or Parent/Guardian (if minor) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of minor Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agreement for Therapy With a Minor**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent/legal guardian of the minor, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

☐ Give my permission for this minor to receive therapeutic services provided by Dane Osborne, MS, LPC.

☐ I have read, understood, and signed the informed consent related to my child’s therapy and I understand the risks and benefits of receiving these services and the risks and benefit of not receiving these services, for both this minor and his, her or their family.

My signature below means that I understand and agree with all the points above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian Date

Health Provider’s Statement

I have inquired to ensure that the patient understood the above description of the limits on confidentiality.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Provider’s Signature Date

**Client Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date-of-Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Male ☐ Female ☐ Transgender

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where would you like me to leave you messages?

☐ Home ☐ Work ☐ Cell ☐ Email ☐ None

In the event of an emergency, whom shall we contact?

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in counseling elsewhere? ☐ yes ☐ no

If yes, please describe

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received counseling or evaluation services? ☐ yes ☐ no

If yes, please describe

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under probation? ☐ yes ☐ no

If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is financially responsible for this account?**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization and Release:** I authorize the release of any information including the diagnosis and records of any treatment or examination rendered to me during the period of such care to third party payors and/or other health practitioners. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I give Dane Osborne, MS, LPC-A, the right to seek the services of a bill-collecting agency in efforts to collect fees that I have not paid for services rendered and/or for cancelled or missed appointments.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**About your Child**

Age \_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Relatives | Name | Age/Grade | How well does child get along with this family member?  1=Poorly to 5=Very well |
| Father |  |  |  |
| Mother |  |  |  |
| Sister(s) |  |  |  |
| Brother(s) |  |  |  |
| Step Father |  |  |  |
| Step Mother |  |  |  |
| Step Siblings |  |  |  |
| Who lives in the child’s home? |  |  |  |

Who is your child’s Pediatrician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any concerns shared by the doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications or drugs your child takes or has taken in the last year, both prescribed and over-the-counter.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Starting with birth and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a history of mental illness in the child’s family? If so, please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything else you are concerned about?

Please mark all of the items that apply to your child. Feel free to add any others.

☐ Accident-prone

☐ Affectionate

☐ Aggressive/Assaults

☐ Anxious/nervous/timid

☐ Argues/defiant/oppositional

☐ Breaks rules/law

☐ Bullied by others

☐ Bullies others

☐ Cheats

☐ Clowns around

☐ Compliant

☐ Complains of feeling sick

☐ Conflicts at school

☐ Conflicts at home

☐ Conflicts with friends

☐ Conflicts with authority

☐ Cruel to animals

☐ Dawdles

☐ Dependent/Clingy

☐ Depressed/Sad

☐ Destructive

☐ Developmentally delayed

☐ Difficulty with parent(s)

☐ Disorganized

☐ Distractible/daydreams

☐ Disrupts family activities

☐ ☐ Drug or alcohol use

☐ ☐ Eating issues

☐ ☐ Failure in school

☐ ☐ Fearful/shy

☐ ☐ Feelings are easily hurt

☐ Fidgety

☐ Fights

☐ Fire setting

☐ Forgetful

☐ Hair chewing

☐ Head banging

☐ Hitting/biting

☐ Hostile

☐ Hyperactive

☐ Hypochondriac

☐ Imaginary playmates

☐ Immature

☐ Inappropriate sexual behavior

☐ Inattentive

☐ Independent

☐ Inflicts pain on others

☐ Insults others

☐ Interrupts

☐ Intimidated by others

☐ Irritable

☐ Isolates/withdraws

☐ Lacks concerns for others

☐ Lacks motivation/Procrastinates

☐ Lacks respect for authority

☐ Learning disability

☐ Legal difficulties

☐ Lethargic

☐ Likes to be alone

☐ Loss of friends

☐ Low frustration tolerance

☐ Lying/manipulates

☐ Moody

☐ Mute, refuses to speak

☐ Nail biting

☐ Needs much supervision

☐ Nightmares/terrors

☐ Noisy

☐ Noncompliant

☐ Only younger playmates

☐ Outgoing

☐ Overactive

☐ Overly obedient

☐ Over sensitive/cries easily

☐ Picks on others/teases

☐ Pouts

☐ Refuses/resists/slow responding

☐ Restless

☐ Rocking or repetitive movements

☐ Runs away

☐ Self-harming behaviors

☐ Sexualized behavior

☐ Sexually active

☐ Smokes

☐ Speech difficulties

☐ Stealing

☐ Stubborn

☐ Suicide talk or attempt

☐ Swearing/talks back

☐ Temper tantrums/rages

☐ Tics-movements or noises

☐ Truancy

☐ Uncooperative

☐ Uncoordinated

☐ Under-active

☐ Unhappy

☐ Violent

☐ Wets bed/clothing

**CONSENT FOR TREATMENT OF CLIENTS**

**INCLUDING MINORS**

In order for me to provide you with counseling services, I must have your informed consent for treatment and to keep a clinical record.

My record keeping system is designed to protect your personal rights and to insure confidentiality. In the process of providing, you with these services there are no other clinicians or staff members who will have access to your records.

Texas and Federal Law protects your privacy and keeps your treatment confidential. However, there are special circumstances that I must report:

• Suspected child abuse, past or present

• Suspected elder or dependent adult abuse

• Threat of harm to self or others

• Court order requiring the sharing of information

If you have concerns or questions about confidentiality, please ask your therapist.

Dane Osborne, MS, LPC-A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Status of Client:**

\_\_\_\_\_\_\_\_\_\_ Minor under the age of 12 \_\_\_\_\_\_\_\_\_\_ Minor age 12-18

\_\_\_\_\_\_\_\_\_\_ Adult \_\_\_\_\_\_\_\_\_\_ Dependent Adult

**Acknowledgement that I/We have received a copy of (initial each):**

\_\_\_\_\_\_\_\_\_\_ Information and Agreement Form

\_\_\_\_\_\_\_\_\_\_ Consent for Treatment Form

\_\_\_\_\_\_\_\_\_\_ Notice of Information/Privacy Practices, which is intended to meet the requirements set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I give my consent for treatment and for the keeping of my clinical records by Dane Osborne, MS, LPC-A

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of client Date of birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client Date

I, as the parent or legal guardian, do authorize Dane Osborne, MS, LPC-A, to provide treatment and keep clinical records of:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of minor Date of birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/guardian Date

Copy given to client \_\_\_\_\_\_\_\_ Original kept by therapist \_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card Authorization Form**

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CVC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

$70 per session charge \_\_\_\_\_\_\_\_\_\_\_\_ *(initial)*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dane Osborne, MS, LPC-A**

**Professional Disclosure Statement**

**Qualifications:** I earned a Masters in Counseling from Southern Methodist University in 2021 and completed all coursework for the License Professional Counselor track. In my work since graduating, I am working toward required 3,000 hours of counseling under the supervision of a Licensed Professional Counselor Supervisor.

**Experience:** I have experience working with adolescents, families, and adults during my year long internship at the SMU Center for family Counseling in Plano and Frisco In addition to that work, I have served as a small group facilitator for FOCUS during college

**Nature of Counseling:** My theory of counseling is Jungian, which is based on the premise that people are whole and striving toward individuation. I believe all individuals have the capacity for growth through thoughtful reflection and deliberate action.

Counseling is an opportunity for you to work on your concerns in an atmosphere of encouragement and acceptance. Ours will be a collaborative relationship in which we will identify appropriate goals and strategies to address your concerns.

**Informed Consent**

**Disclosure of Stuttering:** I have a stutter. This means occasionally when I speak, I may repeat sounds or get stuck on a sound. Sometimes when I am stuck on a sound I may look up. This does minimally increase the time it takes me to speak, however, over the course of the conversation, the moments of stuttering decrease in both duration and severity. People associate stuttering with a lack of confidence or nervousness. This is not the case; it is just how I speak. Stuttering occurs regardless of my emotional state. Although unnecessary, when listening to a person who stutters people may want to assist by completing a word for the speaker or fear that the speaker is uncomfortable or in pain. Stuttering is not painful for me and does not distract me from my work. During moments of stuttering, feel free to do whatever makes you comfortable and in a moment it will pass. Stuttering occurs more often and with more severity when I am on the phone. If you think this may impact our therapeutic relationship, I encourage you to have a conversation with me. By signing below, you acknowledge the above information and consent to therapy where stuttering by the counselor may occur.

**Emergency/Crisis:** Please know that I do not provide a 24-hour crisis counseling service. Should you experience an emergency necessitating immediate mental health attention, immediately call 9-1-1 or go to the nearest emergency room for assistance.

**Assessments:** Dane Osborne does not offer formal assessments. Referrals are available upon request.

**Counseling Relationship:** During the time we work together, we will meet weekly for approximately 50 minutes per session. Although our sessions may be very intimate psychologically, we have a professional relationship rather than a social one. Please do not invite to social gatherings, offer me gifts, ask me to write references for you, or ask me to related to you in any way other than the professional context of our counseling sessions. You will best be served if our sessions concentrate exclusively on you (adult counseling situations) or your child’s concerns (parent consultations for child or adolescent counseling).

**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 a process of 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’s Rights:** If a divorce or separation of parents has occurred, a current copy of the relevant court documents is required to begin services. If joint custody exists, the parent not bringing the child will also be contacted via letter with an intake form and an invitation to that parent to call with any questions and to participate in their child’s counseling—It is the policy of Dane Osborne, to involve both parents (unless parental rights have been restricted by a court order) in the treatment process.

Some clients need only a few counseling sessions to achieve their goals; 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 it is requested 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 counseling services will be rendered in a professional manner consistent with the current ethical practices promulgated by the Ethical Codes of the Texas State Boards of Examiners of Licenses Professional Counselors and the HIPAA security and privacy rules. If at any time or for any reason you are dissatisfied with my services, please let me know so that existing issues can be worked through. If I am not available to resolve your concerns, you may report your complaints.

**Referrals:** Should you and/or I believe that a referral is needed, I will provide some alternatives, including programs and/or people who may be available to assist you. You will be responsible for contacting and evaluating those referrals and/or alternatives.

**Supervision:** I consult on cases with Dr. Rozan Christian, Ph.D., LPC-S. He does not have access to my records.

***Court: I do not agree to serve as an expert witness or to provide testimonial services for you, and you agree not to cause me to be used in this way. Should you or your attorney subpoena me as a factual case witness or involve m in court-related proceedings, you agree to pay the Center $100 for every hour of my time involved including case preparation, travel and witness time. You further agree to ay a retainer fee of $1,000 to the Center at the time a subpoena is served to be applied toward these charges. If a subpoena is issued for me it, will be turned over to our attorney, and I will consult with that attorney as necessary. A bill will be rendered to you for immediate payment when a subpoena is issued. Please let me know before establishing a counseling relationship if you are attending counseling for court-related purposes/motivations.***

By your signature below, you are indicating that you have read and understood this document, and that any questions you had about this document were answered to your satisfaction; that you were furnished a copy of this document, acknowledge your commitment to comply with all of its terms and requirements, issue consent for Dane Osborne, MS, LPC to work with you and/or your child (client over the age of 12 must also sign) and acknowledge understanding and agreement with my financial obligations.

Client’s Signature (over the age of 12) Date

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Guardian’s Signature Date

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Counselor Date

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**HIPAA Notice of Privacy Practices**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health condition and related health-care services.

I am legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. I reserve the right to change my privacy practices and apply revised privacy practices to protected health information.

**Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by me and others outside of my office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of my practice as necessary, and any other use required or permitted by law. The following categories describe reasons that my office typically uses and discloses your medical information, but is not all encompassing. These categories are intended to be generic descriptions only, and not a list of every instance in which I may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your consent in order for us to release your medical information.

Treatment: I will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, I would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Health Care Operations: I may use and disclose your protected information as necessary for health care operations, such as management, personnel evaluation, education and training and to monitor quality of care. For example, I may use and disclose information to make sure the services you receive at my office is of the highest quality.

Individuals Involved in Your Care or Payment for Your Care. I may release medical information about you to a friend or family member who is involved in your medical care, as well as to someone who helps pay for your care, but will do so only as allowed by state or federal law, or in accordance with your prior authorization.

Emergencies. I may use or disclose your protected information as necessary in emergency treatment situations.

Business Associates. I may disclose your protected information to a contractor or business associate who needs the information to perform services for my office. My business associates are committed to preserving the confidentiality of this information, and have signed an agreement with us that holds them to certain privacy standards.

Public Health Activities. I may disclose your protected information for public health activities. These activities may include, for example, reporting to a public health authority for preventing or controlling disease, injury or disability, reporting child abuse or neglect or reporting births and deaths. As a general rule, I am required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services.

Reporting Victims of Abuse, Neglect or Domestic Violence. If I believe that you have been a victim of abuse, neglect or domestic violence, I may use and disclose your protected information to notify a government authority, if authorized by law or if you agree to the report.

To Avert a Serious Threat to Health or Safety. When necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person, I may use or disclose protected information, limiting disclosures to someone able to help lessen or prevent the threatened harm.

Judicial and Administrative Proceedings. I may disclose your protected information in response to a court or administrative order. I also may disclose information in response to a subpoena, discovery request, or other lawful process; efforts will be made to contact you about the request or to obtain an order or agreement protecting the information.

Law Enforcement. I may disclose your protected information for certain law enforcement purposes, including, for example, to comply with reporting requirements; to comply with a court order, warrant, or similar legal process; or to answer certain requests for information concerning crimes.

As Required By Law. I may use or disclose your protected information when required by law to do so.

**Uses and Disclosures with Your Authorization**

Except as described in this Notice, I will not use or disclose any of your protected health information without your specific authorization. You, the patient, may revoke the authorization at any time. If you revoke an Authorization, I will no longer use or disclose your protected information for the purposes covered by that Authorization, except where I have already relied on the Authorization.

**Your Rights Regarding Your Protected Information**

Listed below are your rights regarding your protected information. Each of these rights is subject to certain requirements, limitations and exceptions. Exercise of these rights may require submitting a written request to us. At your request, I will supply you with the appropriate form to complete. If you have questions about how to exercise your rights, please contact my office. You have the right to:

Request Restrictions. You may request restrictions on certain uses and disclosures. You also have the right to request restrictions on the protected information I disclose about you to a family member, friend or other person who is involved in your care or the payment for your care. I am not required to agree to your requested restriction (except that if you are competent you may restrict disclosures to family members or friends), and in some situations I will not be able to agree to your request.

Request Confidential Communications. You have the right to receive confidential communications of your protected health information.

Access to Personal Protected Information. You have the right to inspect and copy your protected health information, subject to some exceptions. In most cases, I may charge a reasonable fee for my costs in copying and mailing your requested information. In certain limited circumstances allowed by law, I may deny your request to review or copy your medical information. If this occurs, you will be notified of the denial and you have the right to have your request and the denial reviewed by another licensed health care professional.

Request Amendment. You have the right to request amendments of your protected information maintained by me for as long as the information is kept if you believe it is incorrect or incomplete. I may deny your request for amendment, but will inform you of the reasons for the denial and the right to submit a written statement disagreeing with the denial.

Request an Accounting of Disclosures. You may also request an accounting of disclosures of your protected health information from this office. This is a listing of disclosures made by us or by others on my behalf, but does not include disclosures for treatment, payment and health care operations, disclosure made pursuant to your Authorization, and certain other exceptions.

Notification of a Breach. You have the right to be notified if your medical information is used or disclosed in a manner that is not permitted by law. In the event of a breach, I am required by law to actively take steps to rectify the disclosure.

**For Further Information or to File a Complaint**

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact our office. If you believe that your privacy rights have been violated, you may file a complaint in writing with us using the contact information listed below or with the Office of Civil Rights in the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint.

**ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received and understood the HIPAA Notice of Privacy Practices for this office:

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Client signature (parent or guardian if minor patient) Date