I would like to take this time to personally thank you for choosing me as your or your child's therapist at this point in your personal journey. It is a difficult yet courageous decision to share one's innermost thoughts, feelings, and burdens with a professional. I hope that we can work together successfully for your or your child's ongoing personal growth, development, and wellness.

My foremost goal is to provide you and your child quality care and service. Feel free to ask any questions regarding your treatment or progress, and please let me know if there is a better way to assist you.

Please complete the following pages in this intake packet, and I will be glad to discuss any questions you have regarding these forms and will provide you with a copy of these forms upon request.

Additionally, let me address a few more details on how Gooden Counseling, PLLC works. Gooden Counseling, PLLC functions as an independent and private outpatient therapy service. Office hours are available by appointment only, and all charges are for time reserved with me or used in your ongoing care. Payment for today and all future appointments is due on the date of service by check, cash, VISA, MasterCard, or American Express. **All payments should be made payable to Gooden Counseling**. **Gooden Counseling, PLLC does adhere to a 24-hour cancellation policy**, meaning a minimum of a 24-hour **(one business day)** cancellation of any time reserved is necessary to avoid a full fee charge **($150)** for a missed appointment.

Finally, I do not provide emergency services, although I do strive to be as accessible to you as possible. If you or your child should experience an emergent situation please call 911 or have someone take you or your child to the nearest emergency room for immediate care. Please be sure to inform me if such a situation occurs, as soon as possible after your or your child's safety has been ensured.

Thank you in advance for taking care and making note of these important administrative details.

Sincerely,

Tiana Gooden, LCSW

GOODEN COUNSELING, PLLC
2000 Highland Village Rd., Suite C
Highland Village, TX 75077
www.goodencounseling.com
(972) 861-0060

CLIENT INTAKE FORM

(Please Print)

Today's Date _____/_____/_____ **Therapist**_____

CLIENT INFORMATION

Client's Last Name First Middle	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address		Home Phone No. ( )
P.O. Box City State ZIP Code		Cell Phone No. ( )
Occupation	Employer	Work Phone No. ( )

Referred to Provider by (Please check one box & list) ❑ Health Care Provider _____ ❑ Website

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Other Referral Phone: _____

Email Address:	Alternative Email Address:
Is Client a Minor? ❑ Yes ❑ No	***IF YES, THEN PARENT/GUARDIAN MUST COMPLETE**:

BILLING INFORMATION (PLEASE SEE OFFICE MANAGER TO MAKE PAYMENT)

Parent/Guardian Name	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Client's Relationship to Payer ❑ Self ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Client	Home Phone No.	Work Phone No.

GOODEN COUNSELING, PLLC

CLIENT INTAKE FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the end of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that it is recommended that I discuss my decision to terminate treatment with my therapist prior to termination. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I understand that by giving the above named individuals and phone numbers for emergency contact that I am providing consent for reasonable communication to these numbers.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

Gooden Counseling, PLLC
Tiana Gooden, LCSW
2000 Highland Village Rd., Suite C
Highland Village, TX 75077
www.goodencounseling.com
(972) 861-0060

GENERAL POLICIES AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

AVAILABLE SERVICES: Gooden Counseling, PLLC offers a wide array of counseling services, including play therapy, individual, family, and group therapy, and parent consultation services. Tiana Gooden, LCSW is a licensed clinical social worker. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is Ms. Gooden's intent to convey the policies and procedures used in this practice, and Ms. Gooden will be pleased to discuss any questions or concerns you may have. ***Initials** _____

COUNSELING: Gooden Counseling, PLLC provides short-term counseling designed to address many of the issues that clients are dealing with. Your first visit will be an assessment session in which you and Ms. Gooden will determine your concerns, and if both agree that Gooden Counseling, PLLC can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by Ms. Gooden, services to you may be terminated. You are responsible for informing Ms. Gooden of all hospitalizations (including IOP and PHP) of psychiatric nature. You are also responsible for informing Ms. Gooden of progress (or lack thereof), side effects, or dangerous thoughts immediately when each session begins. The goal of Gooden Counseling, PLLC is to provide the most effective therapeutic experience available to you. If at any time you feel that you and Tiana Gooden, LCSW are not a good fit, please discuss this matter with Ms. Gooden to determine if a referral or transfer to a more suitable Therapist is right for you. If you and Ms. Gooden decide that other services would be more appropriate, she will assist you in finding a provider to meet your needs. Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Gooden Counseling, PLLC therapy services are designed to provide clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues. ***Initials** _____

RISKS AND BENEFITS: The goals of therapy are to provide information, emotional support, and skills to improve personal effectiveness, promote personal safety, and to develop problem

solving strategies to deal with current problems. Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved family and personal relationships, reduced feelings of emotional distress, improved school and work performance, and enhanced problem solving. Although therapy can be a powerful and life changing process, there are no guarantees about what will happen. Therapy has a natural process to it, which includes a beginning (getting acquainted, identifying problems, setting goals), a middle (treatment activities, exploring approaches, developing solutions), and an ending (evaluation of goal attainment, after care goals, closure and termination activities). To ensure the best results, Ms. Gooden hopes that you will see your therapeutic process through all of these phases. ***Initials** _____

CLIENT/THERAPIST RELATIONSHIP: You and Ms. Gooden have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. The National Association of Social Workers (NASW) Code of Ethics prohibits dual relationships between clinician and client. This applies to both current and former clients. This means as a client, Ms. Gooden cannot meet with you for social occasions or be involved in any business activities with you other than providing psychotherapeutic services. Gifts are not appropriate, nor are any sort of trade of service for service. In addition, it is Gooden Counseling, PLLC's policy to only see family members of clients in a therapeutic collaborative manner, as it relates to the client's treatment. Gooden Counseling, PLLC strives to avoid dual relationships and conflicts of interest which can negatively influence the therapeutic relationship with a client. If a family member of a current or former client verbalizes a need for counseling services, Ms. Gooden will attempt to suggest other resources or referrals for assistance. ***Initials** _____

CONFIDENTIALITY: Gooden Counseling, PLLC follows all ethical standards prescribed by state and federal law. Gooden Counseling, PLLC is required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Please be advised that there are certain situations in which it is required by law to reveal information obtained during therapy to other persons or agencies **without your permission**. These limits to confidentiality in the state of Texas include but are not limited to the following situations:

- Threatening harm or death to yourself (suicide)
- Threatening harm or death to another person (homicide)
- Abuse to a child or of the elderly or disabled
- Abuse of patients in mental health facilities
- Sexual exploitation
- AIDS/HIV infection and possible transmission
- If a court of law issues a subpoena for notes/records
- If the therapy and/or evaluation is court ordered
- If you are seeking payment through an insurance company (client/guardian is responsible for filing own claim)

- If the therapist receives supervision and/or consultation (collaboration with other clinicians) in order to provide you with the best quality care
- Fee disputes between the Therapist and the client
- A negligence suit brought by the client against the Therapist
- The filing of a complaint with the licensing or certifying board

If you have any questions regarding confidentiality, you should bring them to the attention of Ms. Gooden when you and she discuss this matter further. By signing this General Policies and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result. ***Initials** _____

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name Telephone Number

_____ _____

_____ _____

***Initials** _____

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact the office regarding the nature and urgency of the circumstances. Gooden Counseling, PLLC will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, every effort will be made to respond to your emergency in a timely manner and within 24 hours. If your emergency arises after hours or on a weekend, you can leave a voicemail message for Ms. Gooden at 972-861-0060, which will be returned as soon as possible during normal business hours. **Ms. Gooden does not provide emergency counseling services. If you are experiencing a crisis or emergency situation, call 911 or have someone take you or your child to the nearest emergency room for help.** Please notify Ms. Gooden if an "after hours emergency" has occurred so that a follow-up session may be scheduled as soon as possible. ***Initials** _____

COMMUNICATION: Communication is a necessary and vital part of your relationship with your therapist. However, it is very important that you understand the constraints that exist related to different types of communication. As noted earlier, in the **"Confidentiality"** section of this document, all efforts will be made to ensure confidentiality of sessions, within the constraints of Texas law. However, please review the following information regarding telephone, text messaging, and electronic communication:

Telephone Communication: If Ms. Gooden is available, she will respond by cell phone between sessions, and at the beginning and end of her office hours for non-emergencies for up to 10 minutes without charge at **(972) 861-0060**. That number will also accept confidential voice mail messages. Phone calls longer than 10 minutes in length will be billed at my hourly rate, with a minimum of 15 minute increments. **Please note that telephone calls after 5:00 pm will not be returned until the next business day.** If you find yourself facing an emergency situation, please contact emergency services (911) immediately and/or go to your nearest hospital emergency room. (See "Emergencies" section)

Text Messaging: Please feel free to contact your therapist via text messaging at **(972) 861-0060**. This form of communication **cannot** ensure confidentiality and should be reserved for merely scheduling and/or cancelling appointments.

Electronic Communication: When Ms. Gooden is available, she will respond to email communication, as appropriate. However, Gooden Counseling, PLLC **cannot** ensure confidentiality of any correspondence sent via email and **cannot** be responsible for breaches in confidentiality resulting from someone getting your password or having access to your account. Therefore, email communication should be reserved merely for scheduling and/or canceling appointments. If the content of the email from you contains more than scheduling information, your therapist will contact you by telephone to discuss your concerns further and assist you, as able. These telephone conversations will be charged at the hourly rate, as described above, after the first 10 minutes. If further assistance is required, you may also schedule a session with Ms. Gooden. Additionally, **all email correspondence between you and your therapist will be printed and placed in your (or your child's) file**. Your therapist will attempt to respond by email or telephone, depending on the situation and content of the email, within 24 hours or one business day.

I consent for the undersigned therapist to communicate with me by mail and by telephone at the following address(es) and phone number(s). I will **IMMEDIATELY** advise the therapist in the event of any change:

Address	**Telephone Number**
_____	_____
_____	_____

***Initials** _____

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by you and your Therapist.

Sometimes setting up a set weekly or biweekly appointment time is the best way to ensure that you will be able to get an appointment time or one that best fits your schedule. However, if you make this kind of appointment, you are committed to that time until you specifically tell me you would like to give it up. If two set appointments are missed, I will only be able to schedule with you on a week-to-week basis to open space for clients that need set appointment times. Payment is expected in full at the time of service.

If you must cancel or reschedule your appointment, please call our office at (972)-861-0060 at least 24 hours in advance. This will free your appointment time for another client and every effort will be made to reschedule in a timely manner. **Gooden Counseling, PLLC does adhere to a 24-hour cancellation policy**, therefore any appointments missed or cancelled with less than 24-hour **(one business day)** notice will be charged at **full fee ($150)**. We understand that emergencies and health problems do come up and we are willing to consider them when adequate notice is given. However "no-shows", last minute scheduling conflicts with other professionals, sports events, family events, or work/school scheduling conflicts generally will not be considered. Repeated "no-show" appointments could result in you being referred out of this practice to another practitioner.

You will only be considered an active client of this practice if you keep each appointment or makes alternative appointments with this office. After the passage of 45 days without contact between you and your Therapist, you will be considered an inactive client. Please be aware that inactive status officially **CLOSES** your case. Please note that the therapist may terminate the counseling relationship after 2 missed appointments without calling to cancel 24 hours prior to your scheduled appointment. Additionally, any balance on the account for missed appointments must be paid prior to rescheduling an appointment. Inactive status may be instituted after two appointments missed without cancellation notice. ***Initials** _____

FEE SCHEDULE:

Diagnostic & Evaluation Session (1st visit – 90 min.)	$225
Regular Office Sessions (50 min.) (Individuals, Parent Consultation/Coaching & Family Therapy)	$150
Play Therapy Sessions (45 min.)	$150
Family Sessions (90 minutes)	$225
Group Therapy	(varies by group)
All Other Services, 150/hour, prorated by 15 minutes	$150
Late Cancellation, less than 24-hour or one business day notice	$150
Missed Appointment	$150
Returned check fee per check	$45

***Initials** _____

COURT FEES: If you are currently involved or become involved with any legal proceedings, please inform me as soon as possible. It is important that we discuss how the proceedings might impact our work together. If legal actions occur in which you will be responsible to pay me for the following **even if the subpoena is sent from the opposing side of the case**; (a) the time spent for travel to/from court at the rate of $500.00 per hour; (b) the time spent on preparing testimony, reports, witness time, and depositions at the rate of $500.00 per hour; (c)the time spent on mediations and court appearances are billed at $1,000 per half-day and $2,000 per full-day. All fees must be paid in full prior to any work being done on the legal case.
***Initials** _____

MEDICAL RECORDS: $30 for the first twenty pages and $.75 per page for every copy thereafter. In addition, a reasonable fee may include actual costs for mailing, shipping, or delivery. If an affidavit is requested, certifying that the information is a true and correct copy of the records, a reasonable $30 may be charged for executing the affidavit. ***Initials** _____

LETTERS/DOCUMENTATION: The charge will be determined by the amount of time spent to complete the request. ***Initials** _____

PAYMENT/INSURANCE FILING: Clients or Parents/Guardians are responsible for payment for all services rendered. Payment is due by the end of each session. Payment may be made with cash, check, or credit card. Gooden Counseling, PLLC is an out-of–network provider, if you choose to file your own claim with your insurance company, full payment will be expected at time of service and a completed receipt will be provided at the end of each session documenting the service delivered and fees paid. Additionally, if an insurance company is paying for any part of your counseling treatment, they may require that Ms. Gooden provide them with a psychiatric diagnosis in order to be paid. They may request information regarding treatment plans and progress made during treatment. Ms. Gooden will be happy to discuss with you any information that is shared with your insurance provider. Also, your insurance company may limit the number of sessions you have available or deny coverage for the services you are seeking help for (such as group or family counseling). Therefore, Gooden Counseling, PLLC advises that you verify your benefits before your first appointment. ***Initials** _____

CREDIT CARD CONSENT: The below credit card information, provided by the client or parent/guardian, will be placed on file. By signing this agreement you are agreeing to allow Gooden Counseling, PLLC to charge below listed credit card for any "no show, no call" appointments, late cancellations made inside of 24 hours of set appointment, and any telephone or ancillary charges (returned check fees, requested letter or documentation fees, and any requested medical record copying fees). ***Initials** _____

Type of Credit Card (circle): American Express/ Visa/ MasterCard/ Discover/ FSA or HSA

Name (as printed on card): _____

Credit Card Account Number: _____

Expiration Date: _____ 3-4 Digit Security Code/CVC: _____

Billing Address for Credit Card: _____

City_____ State_____ Zip_____

Email Address: _____ (to receive electronic copies of receipts)

By my signature below, I also request and provide Gooden Counseling, PLLC my permission to charge the above listed account for ongoing regular therapy sessions according to the fee schedule, described above in this document.

Printed Name: _____

Signature of Cardholder: _____ Date: _____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby

consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing. ***Initials** _____

DISCONTINUING TREATMENT: I understand that I am free to discontinue treatment at any time and that I agree to notify Gooden Counseling, PLLC immediately so that I may be provided with referrals for continued care. Additionally, Gooden Counseling, PLLC has the right to terminate your treatment at any time. Some of the reasons include but are not limited to: boundary violations, non-compliance with treatment, failing to follow appointment policies and procedures, and non-payment of fees and/or services rendered. Should your therapist decide to discontinue treatment, you will be provided notification of such and a referral source for another psychotherapy professional or agency, if requested. ***Initials** _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA): Federal law, HIPAA, provides privacy protection for medical records and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires we provide you with a Notice of Privacy Practices. The Notice of Privacy Practices, which is contained within this agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires we obtain your signature acknowledging we have provided you with this information at the end of this session (Notice of Privacy Practices/HIPAA Receipt).
***Initials** _____

CONSENT TO TREATMENT: By signing this Client General Policies and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. **NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Gooden Counseling, PLLC will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.**

_____
Name of Client (Please Print)

_____ _____
Signature – Client/Parent Date

_____ _____
Signature – Spouse/Partner/Parent Date

_____ _____
Signature of Therapist Date

GOODEN COUNSELING, PLLC
2000 Highland Village Rd., Suite C
Highland Village, TX 75077

www.goodencounseling.com
(972) 861-0060

CONSENT FOR TREATMENT OF A MINOR

We/I, the undersigned _____, parent(s) and/or guardian(s) of a minor child _____, give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability.

PLEASE NOTE: If you are consenting to treatment of a minor child, if a court order and/or divorce decree has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Gooden Counseling, PLLC will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order and/or divorce decree.

_____ _____
Signature of Mother or Guardian Date

_____ _____
Signature of Father or Guardian Date

_____ _____
Signature of Therapist Date

GOODEN COUNSELING, PLLC
2000 Highland Village Rd., Suite C
Highland Village, TX 75077
www.goodencounseling.com
(972) 861-0060

NOTICE OF PRIVACY PRACTICES/HIPAA

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

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to Tiana Gooden, LCSW, at Gooden Counseling, PLLC:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions. .** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Tiana Gooden, LCSW, at Gooden Counseling, PLLC, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is August 1, 2013.

GOODEN COUNSELING, PLLC
2000 Highland Village Rd., Suite C
Highland Village, TX 75077
www.goodencounseling.com
(972) 861-0060

Notice of Privacy Practices/HIPAA
Receipt and Acknowledgment of Notice

Client Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Gooden Counseling, PLLC Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Tiana Gooden, LCSW at Gooden Counseling, PLLC.

_____
Signature of Client

_____
Signature or Parent, Guardian or Personal Representative*

_____
Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ Client Refuses to Acknowledge Receipt:

_____
Signature of Therapist Date