



Dr. Gina Galloway, P.L.L.C.

Licensed Professional Counselor

Adult Client Information

Today's Date _____

Home Phone _____

Cell Phone _____

Work Phone _____

Client's Name _____

Address _____ City _____ State _____ Zip _____

E-mail _____

Age _____ Date of Birth _____

Male Female Single Married Divorced Widowed

Where would you like me to leave you messages?

Home Work Cell E-mail None

If there is an emergency at the office and we must cancel your appointment, where should we call? Home Work Cell E-mail None

Employer-Self _____ Occupation _____

Employer-Spouse _____ Occupation _____

Why are you seeking counseling?

ABOUT YOUR FAMILY

Relative	Name	Living? Yes/No	Age or Age at Death	Deceased? Yes/No	Occupation
Father					
Mother					
Sister(s)					
Brother(s)					
Other Significant Persons					

PLEASE CHECK ANY PAST, PRESENT, OR IMPENDING SPECIAL PROBLEMS IN YOUR FAMILY

- | | | |
|---|--|---|
| <input type="checkbox"/> divorce | <input type="checkbox"/> frequent relocations | <input type="checkbox"/> eating disorders |
| <input type="checkbox"/> alcohol/drug abuse | <input type="checkbox"/> serious illness | <input type="checkbox"/> psychiatric disorder |
| <input type="checkbox"/> physical/sexual abuse | <input type="checkbox"/> financial crisis | <input type="checkbox"/> legal problems |
| <input type="checkbox"/> debilitating injuries/disabilities | <input type="checkbox"/> attempted/completed suicide | |

Have you personally experienced significant family abuse?

- None
 Unsure
 Emotional
 Physical
 Sexual

Have you personally experienced legal problems? No Yes

Did you experience learning problems in school?

- None
 Little
 Substantial
 Constant Struggle

In general, how happy or adjusted were you growing up?

- Happy
 Average
 Not Happy

Who in your family do you currently feel closest to?

Most distant from? _____ In most conflict with? _____

ABOUT YOUR HEALTH

Who is your doctor? _____ When was the last visit? _____

Any concerns shared by the doctor?

Describe any allergies you have

Do you have any chronic medical concerns? _____ Please list _____

Do you have a Mental Health diagnosis? If so, which one

Are you under the care of a Psychiatrist? If so, whom _____

Have you been prescribed any psychotropic drugs by your Psychiatrist? Yes No

List all medications or drugs (legal or illegal) you have taken in the last year

List all diseases, illnesses, important accidents and injuries, periods of loss of consciousness, convulsions/seizures, and any other medical condition you have had.

ABOUT YOUR CONCERNS

Please mark all of the items that currently apply. Feel free to add any others under "Any other concerns."

- | | | |
|--|--|--|
| <input type="checkbox"/> Abuse-emotional | <input type="checkbox"/> Abuse-neglect | <input type="checkbox"/> Abuse-physical |
| <input type="checkbox"/> Abuse-sexual | <input type="checkbox"/> Aggression | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arguing | <input type="checkbox"/> Attention Problems |
| <input type="checkbox"/> Career concerns | <input type="checkbox"/> Childhood issues | <input type="checkbox"/> Children-care |
| <input type="checkbox"/> Children-custody | <input type="checkbox"/> Children-management | <input type="checkbox"/> Choices I have made |
| <input type="checkbox"/> Codependence | <input type="checkbox"/> Compulsions | <input type="checkbox"/> Compulsive spending |
| <input type="checkbox"/> Concentration Problems | <input type="checkbox"/> Confusion | <input type="checkbox"/> Crying |
| <input type="checkbox"/> Deaths | <input type="checkbox"/> Debt | <input type="checkbox"/> Decision making |
| <input type="checkbox"/> Delusions (false ideas) | <input type="checkbox"/> Dependence | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Eating-vomiting | <input type="checkbox"/> Eating-overeating |
| <input type="checkbox"/> Eating-under-eating | <input type="checkbox"/> Emptiness | <input type="checkbox"/> Failure |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fears | <input type="checkbox"/> Financial troubles |
| <input type="checkbox"/> Friendship problems | <input type="checkbox"/> Gambling | <input type="checkbox"/> Grieving |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Headaches, pains | <input type="checkbox"/> Health |
| <input type="checkbox"/> Hostility | <input type="checkbox"/> Impulsive spending | <input type="checkbox"/> Impulsiveness |

- | | | |
|--|---|--|
| <input type="checkbox"/> Indecision | <input type="checkbox"/> Inferiority feelings | <input type="checkbox"/> Inhibitions |
| <input type="checkbox"/> Interpersonal conflicts | <input type="checkbox"/> Irresponsibility | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Judgment problems | <input type="checkbox"/> Laziness | <input type="checkbox"/> Legal matters |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Loss of control | <input type="checkbox"/> Low frustration tolerance |
| <input type="checkbox"/> Marital conflict | <input type="checkbox"/> Marital infidelity/affairs | <input type="checkbox"/> Medical concerns |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Obsessions | <input type="checkbox"/> Outbursts |
| <input type="checkbox"/> Oversensitive | <input type="checkbox"/> Panic or anxiety attacks | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Phobias | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Re-marriage | <input type="checkbox"/> Sadness | <input type="checkbox"/> Self Abuse |
| <input type="checkbox"/> Self-control | <input type="checkbox"/> Self-esteem | <input type="checkbox"/> Separation |
| <input type="checkbox"/> Sexual conflicts | <input type="checkbox"/> Shyness | <input type="checkbox"/> Sleep-nightmares |
| <input type="checkbox"/> Step parenting | <input type="checkbox"/> Stress | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Temper problems | <input type="checkbox"/> Violence | <input type="checkbox"/> Weight and diet issues |
| <input type="checkbox"/> Withdrawal, isolating | Any other concerns? _____ | |

Professional Disclosure Statement And Informed Consent

PLEASE INITIAL EACH ITEM:

_____ I understand that Dr. Gina Galloway, Ph.D. is a Licensed Professional Counselor in the state of Texas.

_____ I understand that Dr. Gina Galloway 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 also understand our contact will be limited to counseling sessions except, only in case of emergency, you may call Dr. Galloway at 817-932-3105. Emergency phone calls will be billed at \$3.00 per minute and will be due at the next session.

_____ I understand that, at any time, I may initiate a discussion of possible positive or negative effects of entering into the counseling relationship and that 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. If at any time I am dissatisfied with Dr. Gina Galloway's services as a therapist, I have a right to let her know. If I do not feel that Gina may resolve my complaint, I may file a formal complaint through 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, along with protection of my confidentiality, and that Dr. Galloway does not initiate the greetings.

_____ Should I believe that a referral is needed, Dr. Galloway will provide some alternatives including programs and/or people who may be able to assist me.

_____ I understand that the rate for individual counseling sessions is \$120.00 for a 50-minute session.

_____ I understand that the rate for couples and family counseling is \$120.00 for a 50-minute session.

_____ I understand that all fees for counseling are due prior to or at the time of each session. If I am late for an appointment, I must still pay for the full session.

_____ I understand that the rate for all subsequent therapy services such as: attending parent/teacher conferences, attending ARD meetings, conducting classroom observations, participating in legal depositions, interactions with insurance companies, consultations with attorneys, etc. will be billed at \$120.00 per hour in 10-minute increments.

_____ I understand that should I subpoena Dr. Gina Galloway as a factual case witness or involve her in any court-related processes, Dr. Galloway charges a retainer fee of \$1,000.00, with an additional \$120.00 every hour she is involved in legal depositions, case preparation, travel, and witness time. The party issuing the subpoena is responsible for the fee. Even though you are responsible for the testimony fee, it does not mean that Dr. Galloway's testimony will be solely in your favor. Dr. Galloway can only testify to the facts of the case and to her professional opinion.

_____ I understand that if I do issue Dr. Gina Galloway a subpoena without her approval (see above) that my subpoena will be directly turned over to her attorney and a bill will be rendered to me for immediate retainer fee payment.

_____ I understand that if a check is returned, a processing fee of \$25.00 will be assessed to my account. Additionally, I will need to make a cash or money order payment for the returned check and \$25.00 processing fee. After a returned check, the office of Dr. Gina Galloway may require cash payment of future appointments.

_____ I understand that if a returned check is not cleared up in 30 days, Gina Galloway will file a suit with the Tarrant County District Attorney's Office.

_____ 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, the fee for calling to cancel on the day of my appointment is \$60.00.

_____ I understand that not showing up for an appointment will result in my being charged \$120.00 for full for the full missed session.

_____ I understand that Dr. Galloway **DOES NOT** allow recording of any kind, including hand-held tape recording, video recording, or cellular phone recording during counseling sessions or telephone conversations without prior written consent.

_____ I understand that my records and all of our communications become part of the clinical record. Records are the property of Dr. Gina Galloway. Adult client records are disposed of seven (7) years after the client has stopped receiving services. **It is Dr. Galloway's policy to not release clinical records.**

_____ 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 yourself or someone else.
- In situations of suspected child, spouse, or elder abuse, it is the duty of the mental health provider to notify medical, legal, or other authorities.
- You disclose sexual contact with another mental health professional.
- If you are involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
- Dr. Gina Galloway is ordered by a court to disclose information.
- You direct Dr. Gina Galloway in writing to release your records.
- If Dr. Gina Galloway receives consultation in order to provide you with the best quality care.
- Dr. Gina Galloway is otherwise required by law to disclose information.

MENTAL STATUS INFORMATION

Have you or your spouse/significant other ever attempted suicide or harmed yourself in any way? Yes No

Are you or your spouse/significant other currently thinking about suicide or harming yourself in any way? Yes No

Have you or your spouse/significant other 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 spouse/significant other 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 I solemnly swear that all of the above information is true to the best of my knowledge

Client Signature

Date

AGREEMENT FOR THERAPY

I, _____

- Agree to receive therapeutic services provided by Dr. Gina Galloway.
- I have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both myself and my family.
- Furthermore, I understand that I am expected to be an active participant in this process.
- I acknowledge that I have received and understand the Notice of Privacy Practices for this office.
- My signature below means that I understand and agree with all of the points above.

Client Signature

Date

HEALTH PROVIDER'S STATEMENT

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

Health Provider's Signature

Date

HIPPA 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 we 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 or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist and others outside of our 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 the therapist's practice as necessary, and any other use required by law.

Treatment: We 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, we 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 insure 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.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

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

Client signature (parent or guardian if minor patient)

Date

Consent for Use and Disclosure of Health Information:

I hereby permit and release Dr. Gina Galloway to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

Client signature (parent or guardian if minor patient)

Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent