GALLOWAY COUNSELING CENTER

8821 Davis Boulevard, Suite 300, Keller, TX 76248 • (817) 932-3105 • www.gallowaycounseling.com

INFORMED CONSENT

POLICIES AND PROCEDURES
CLIENT CONSENT FOR TREATMENT SERVICES

I am glad that you are here, and I am committed to providing you with quality care. Please take a few minutes to read the following information that will explain my office policies and procedures to you. If you have any questions, please ask and I will be happy to clarify any of the information on this form. Please sign and date this form acknowledging that you have read and fully understand the information and are consenting to begin therapy with me. If you are seeking help for your minor child, please additionally complete, sign and date the Consent for Treatment of a Minor Child form. Please read the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices, and then sign and date the form acknowledging that you have read and understand the HIPAA policies. Finally, please read and sign the attached waiver that details potential risks to your confidentiality. Thank you.

Qualifications and Services: Your therapist is _____, who is answerable to the Texas State Board of Examiners of Professional Counselors and her Professional Code of Ethics. During the first few sessions, we will be working toward developing an understanding of your needs and a plan for you and/or your family. We will direct our mutual efforts toward agreed upon goals determined on an individual basis. Since therapy involves a commitment of your time, energy and finances, you should be sure that you are comfortable working with me. If you decide at any time that you are not a good fit or that other services are needed, I will provide you and/or your family with appropriate referrals. For therapy to be successful it calls for an active effort on your part and will require you and/or your family to work on issues and tasks discussed during the session, and also at home. While benefits are to be expected from the therapy process, specific results are not guaranteed and there are inherent risks. Counseling is a 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 changes cannot be predicted. Together we will work to achieve the best results for you.

Confidentiality: I follow the ethical standards prescribed by state and federal law, and my professional governing organizations. Discussions between us are confidential and you have the right to a confidential relationship with me. I am required by practice guidelines and standards of care to keep records of your counseling or therapy. All of our communication becomes part of yours and/or your family's clinical record. These records are confidential pursuant to certain legal and ethical limits and

clinical parameters, and the HIPAA Notice of Privacy Practices provided to you. Within these limits, the information revealed by you during the course of therapy will be kept confidential. No information will be released without your written consent and authorization unless mandated by law. Possible legal exceptions to confidentiality include, but are not limited to, the following situations:

- If you reveal information that indicates you are a danger to yourself or someone else necessitating a duty to protect or duty to warn.
- If you reveal information about child abuse, neglect, elder abuse or sexual exploitation.
- If you are in therapy as a result of a court order, unless otherwise stated in the court order.
- If I receive a subpoena or a court order to disclose information.
- If you provide written permission or direction to release your record.

Duty to Warn / Duty to Protect: If my counselor at Galloway Counseling Center believes that I (or my child if my child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to Dr. Galloway to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger.

By signing this Information and Consent form, you are giving consent for me to share confidential information with all persons mandated by law or for whom you have provided written permission and you are releasing and holding me and my staff harmless for any departure from your right of confidentiality that may result.

If you have any questions or concerns regarding confidentiality, please discuss them with me before signing this form.

Minors and Parents: Clients under 18 years of age who are not emancipated from their parents, should be aware that the law may allow parents to examine their child's treatment records. However, if the treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse, the law provides that parents may not access their child's records. For all individuals, privacy in psychotherapy is often crucial to successful progress and there can be long-lasting negative effects if the client feels her confidentiality has been breached. It is my clinical preference, if necessary, to release summaries, with general information about the treatment goals and progress of the child's treatment and his/her attendance at scheduled sessions. If I feel that the child is in danger or is a danger to someone else, I will notify the parents and/or appropriate authorities of my concern. It is also part of my practice to work with parents, in a counseling type of role, to help them learn ways they can be most helpful to their child at home.

Court Ordered Therapy: If you or your family's therapy has been ordered by court, there are further limitations imposed on your rights as a client. These may include the decision to delineate the number of sessions available to you, or require your participation at a specified frequency. Under these circumstances, a report of your attendance and your progress in therapy may be required. I do not have control over any aspect of the rules or stipulation made by the court, but will take steps to protect your privacy to the extent possible.

Appointments: Services are by appointment only. You are responsible for keeping your appointment and arriving on time. In the event that you cannot keep an appointment, it is your responsibility to call the office at least 24 hours in advance to cancel or reschedule. Please help me serve you better by being responsible for keeping your scheduled appointments. The telephone is answered either by the

office manager or voice mail, so messages can be left 24 hours a day, 7 days a week. Due to my appointment schedule, it may be several hours before I can return your call. Calls received late in the day may not be returned until the following day. After-hours or weekend calls and emails are generally not returned until the next day or the following Monday as I do not check either voicemail or email after work hours or on the weekend.

Emergencies: You may encounter a personal emergency that may require prompt attention. Please contact my office and I will make reasonable efforts to respond to your emergency in a timely manner. If it is after-hours or on a weekend, or you reach the office voice mail during an emergency situation, please go to the nearest emergency room and ask for assistance regarding a mental health emergency, or call 911. When I am out of town, I will provide the name and contact information for an on-call therapist.

We may utilize unencrypted email as a means of communication on a limited basis, but I will not engage in therapy over the Internet. Any type of audio/visual recording is prohibited in therapy sessions, without prior discussion and my consent.

If you are seeking treatment as a function of a court order, I require a hard copy of the court order. If you are seeking treatment for your child and are divorced, separated, or currently involved in any legal proceedings, you must submit a hard copy of your divorce decree and any additional court orders currently in effect that supplement the degree. In so doing, you are documenting that you have the legal right to seek treatment for your child.

Termination of Therapy: Therapy is not mandatory unless you are in treatment as a function of a court order. Unless it is court ordered, you may choose to leave therapy at any time, but this decision is best accomplished in consultation with me. You have the right to discuss positive and negative effects of counseling with me. My goal is to provide services to you in a professional and ethical manner. If you are dissatisfied for any reason please, discuss your concerns with me.

Financial Policy: All appointments are generally 45-50 minutes and are billed on a per session basis. Sessions may be scheduled for a longer period of time and such instances are billed on a prorated basis. If you called to cancel your scheduled appointment at least 24 hours in advance you will not be charged. If you provide less than 24-hour notice, there will be a full-fee charge, emergency situations notwithstanding. I will evaluate each such circumstance and a determination as to the charge will be made at that time. Clients will not be billed for *brief*, miscellaneous emails or *concise* phone calls regarding scheduling or other questions. However, I reserve the right to bill for excessive out-of-session communications, if that becomes a significant issue and will discuss it with you at the time should this become necessary. I do bill for any telephone conference with you or other professionals, which require formal scheduling on my calendar. Full payment is due at the time of service and I accept cash, checks, or credit card payment. Returned checks will be assessed a $25.00 administrative fee for each occurrence. I do not accept third-party insurance reimbursement and your insurance company would consider me an out-of-network provider. If you are not the responsible party, then the responsible party must provide a retainer or credit card on file.

Fee Structure:

General Therapy or Counseling with an LPC-I:	$80.00 per session
General Therapy or Counseling with an LPC:	$120.00 per session
Animal Assisted Therapy	$140.00 per session
General Therapy or Counseling with Dr. Galloway:	$160.00 per session
Divorce/Court-Related Therapy/Counseling with Dr. Galloway * :	$200.00 per session
Court Appearance/Deposition by:	$250.00 per hour (min. 4 hours)

* Individual (adult or child), couple, or family counseling that is either ordered by court, as a result of an agreed court order, mediated settlement agreement, or Rule 11 agreement, or is in regard to or related to a divorce, court case, or legal matter. Will also apply if referred by a Parenting Facilitator or Parenting Coordinator.

** Court/Deposition fees incurred include time for travel, preparation, and actual appearance time, billed at the stated hourly rate, with a **4-hour minimum charge**. Payment is due 48 business hours in advance and is **non-refundable**. Any additional time spent on the day of the court/deposition appearance will be billed within 24 hours and is expected to be paid in full within 48 hours of the bill being sent. Out-of-pocket expenses associated with travel shall also be billed to you with the same expectations of payment.

You are responsible for any legal fees that I incur as related to your case or treatment.

I reserve the right to suspend services if there is an unpaid balance in your account.

Consent to Treatment: By signing this Client Information and Consent Form as the client or guardian of the 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 receive mental health treatment and services for me (or my child if my child is the client) from _____. I understand that I may stop such treatment or services, not under court order, at any time.

_____

Printed Name(s)

_____ _____

Signature – Client / Parent Date

_____ _____

Signature – Client / Parent Date

_____ _____

Signature – Counselor Date

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NEW CLIENT INTAKE FORM

CLIENT INFORMATION:

Last Name: _____ First Name: _____ MI: ___ Nickname: _____

Last 4 of SS#: _____ Sex: M F DOB: _____ Marital Status: _____

Mobile Phone # _____ Home Phone # _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Referred By: _____

PAYMENT INFORMATION:

Person Responsible: _____ Relationship to Client: _____

Address: _____ City: _____ State: _____ Zip: _____

Mobile Phone # _____ Home Phone # _____

Email Address: _____ Marital Status: _____

IF CLIENT IS A MINOR, PARENT INFORMATION:

Name: _____ Relationship to Client: _____

Address: _____ City: _____ State: _____ Zip: _____

Mobile Phone # _____ Home Phone # _____

Email Address: _____ Marital Status: _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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WAIVER

The following business practices, though not all-inclusive, may constitute a potential risk to your confidentiality, in spite of the security measures that I have in place to protect your privacy. By signing below, you understand and acknowledge the possible risk and your consent for such practices to be utilized.

- Use of an electronic calendar
- Use of a paper calendar
- Use of a cell phone for communication with you or other professionals
- Use of a laptop computer
- Use of unencrypted email
- Use of computerized billing
- Use of shared administrative staff

Printed Name(s)

Signature – Client / Parent

Date

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HIPAA AUTHORIZATION FORM

I, _____, whose date of birth is _____ authorize Galloway Counseling Center to disclose to and/or obtain from:

_____,

whose address is _____

phone number: _____ fax number:_____

the following information regarding _____

Description of Information to be Disclosed (*Client should initial each item to be disclosed*)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Testing Information
_____ Educational Information
_____ Presence / Participation in Treatment
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Other _____

In addition, I authorize this disclosure to include health information relating to (*Check if applicable*)

☐ HIV/AIDS Test Results / Treatment
☐ Drug, Alcohol or Substance Abuse Records (including those covered under 42 CFR part 2)

Purpose of Disclosure

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If for other purpose, please specify:

_____

Revocation of Authorization

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Galloway Counseling Center at the above address. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Effective Time Period / Expiration

This authorization is valid until the earliest of one of the following: occurrence of death of the individual, the individual reaches the age of maturity, authorization is revoked in writing, 365 days from the date of signing, or on the following specified date: _____. (*This is the date the form expires on, not today's date*)

Conditions

I further understand that Galloway Counseling Center will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: could potentially impact your therapeutic process and treatment plan.

Other: _____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that I deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and that Federal or state privacy laws may no longer protect the protected health information.

Signature Authorization

I have read this form and agree to the uses and disclosures of the information, as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health and Safety Code 181.151 (c) and/or 45 C.F.R. 164.502(a)(1). Upon request, I will be given a copy of this authorization for my records.

_____

Printed Name

_____ _____

Signature of Client Date

_____ _____

Signature of Parent(s), Guardian or Legally Authorized Representative Date

If you are signing as a representative, specify relationship to client:

☐ Parent(s) of Minor ☐ Guardian ☐ Other: _____

A minor individual's signature is required for the release of certain types of information including, for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse and mental health treatment.

_____

Printed Name

_____ _____

Signature of Minor Client Date

<u>Refusal to Sign Authorization</u>:

_____ **Initial here if client refuses to sign authorization.**

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CONSENT FOR TREATMENT OF A MINOR CHILD

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

_____

Printed Name(s)

_____

Signature – Client / Parent

_____ _____

Relationship to Child Client Date

In Cases of Separation or Divorce:

I have provided legal documentation such as divorce decree or current court orders regarding conservatorship and my legal right to consent to treatment for my child. _____ (Parent Initials)

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ADVISEMENT FORM

1. There is no recording of any kind permitted in the offices of Galloway Counseling Center.
2. Clinical information is not shared over email, unless deemed absolutely necessary by Galloway Counseling Center.
3. Phone calls and emails are billed at the counseling rate that applies to you or your child, in fifteen (15) minute increments.
4. In cases of active litigation or post-divorce, anything released from our office in writing, goes to both parties/attorneys.
5. Our attorney will be in attendance for any depositions and possibly court hearings, if they are contentious enough that we believe it to be necessary. You are responsible for any and all legal fees incurred as related to your case.
6. There are always serious concerns about releasing clinical notes, which are written by and for the clinician, to parents of minors. We believe it is potentially damaging to the child, the therapeutic relationship, and can often have farther-reaching consequences to the client. We preferred to release a clinical summary, if that is agreeable. That being said, we will of course follow the obligations outlined in the Texas Health and Safety Code regarding the release of records.
7. There is a 24-hour cancellation fee. If you do not cancel by that time, you will be billed for the full amount of the session. The counselors will review specific situations individually when it is in regard to illness or other unpredictable challenges.
8. Please do not come or bring sick children to therapy if they have had a fever or vomiting within the last 24 hours. Please also use best judgment on other illnesses, as well, and notify the counselor as soon as possible, so the session can be offered to those on the waiting list.
9. Payment for sessions are due at the time of service. We accept cash, checks, and credit cards.
10. Any and all information provided the counselor or office staff is part of the clinical file. If we counsel with your child or adolescent, HIPAA does not apply to parents -- only the identified patient.

I, _____, agree to abide by the items listed above in the Galloway Counseling Center advisement form.

_____

Printed Name(s)

_____

Signature of Client / Signature of Parent or Guardian (if client is a minor)

_____ _____

Relationship to Child Client Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

I hereby acknowledge that I have received a copy of Galloway Counseling Center's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Signature of Patient or Legal Representative | Date

_____

Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, _____/_____/_____ but acknowledgment could not be obtained because:

- ☐ Patient / representative refused to sign
- ☐ An emergent situation prevented us from obtaining acknowledgement at this time (will attempt at later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain): _____

_____

_____

_____

- ☐ Other (Specify): _____

_____

_____

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NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: _____

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.*

UNDERSTANDING YOUR HEALTH RECORD / INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you to make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information.** However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
    - Was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment
    - Is not part of your medical or billing records
    - Is not available for inspection as set forth above
    - Is accurate and complete

    In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.

6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than you, except for disclosures:
    - To carry out treatment, payment and health care operations as provided above
    - To persons involved in your care or for other notification purposes as provided by law
    - To correctional institutions or law enforcement officials as provided by law
    - For national security or intelligence purposes
    - That occurred prior to the date of compliance with privacy standards (April 14, 2003)
    - Incidental to other permissible uses or disclosures
    - That are part of a limited data set (does not contain protected health information that directly identifies individuals)
    - Made to patient or their personal representatives
    - For which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured protected health information.**

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with the notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a website that provides information about our patient or customer services or benefits, the new notice will be posted on that website.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) most uses and disclosures of psychotherapy notes, (ii) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications, (iii) disclosures that constitute a sale of your health information, (iv) other uses and disclosures not described in the notice. Except as noted above you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our privacy officer Dr. Galloway at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the privacy officer at Galloway Counseling Center or with the Secretary of the U.S. Department of Health and Human Services or Texas Attorney General's office. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

The contact information to file a complaint is included below.

U.S. Dept. of Health and Human Services	**Office of the Texas Attorney General**	**Galloway Counseling Center**
Office of the Secretary	Consumer Protection Division	Dr. Gina Galloway, Privacy Officer
200 Independence Avenue, S.W.	PO Box 12548	8821 Davis Boulevard, Suite 300
Washington D.C., 20201	Austin, TX 78711-2548	Keller, TX 76248
Tel: (202) 619-0257	Tel: (512) 463-2100	Tel: (817) 932-3105
Toll Free: 1-877-696-6775	Toll Free: 1-800-252-8011	

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's website (if applicable website exists) for downloading.

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NEW CLIENT DOCUMENT CHECKLIST

Please have the following forms completed and with you when you arrive for your intake appointment:

_____ Consent for Treatment Services Form

_____ New Client Intake Form

_____ Waiver Form

_____ Advisement Form

_____ HIPAA Authorization Form

_____ Consent for Treatment of a Minor Child Form

_____ Acknowledgment of Receipt of Privacy Practices Form

_____ Any current court orders (if client is a minor and/or if you or your child are court ordered to participate in therapy.)

_____ A file-stamped copy of your entire divorce decree (if you are divorced, and the client is your child.)

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

Your medical information may be used and/or disclosed for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support function of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example, in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings, or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fundraising: Unless you notify us you object, we may contact you as part of a fundraising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fundraising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research (inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

8821 Davis Boulevard, Suite 300, Keller, TX 76248 • 817-932-3105 • www.ginagalloway.com

GALLOWAY COUNSELING CENTER

CLIENT CREDIT CARD AUTHORIZATION AGREEMENT

Name_____

Billing address_____
Street/city State Zip code

Client hereby authorizes Galloway Counseling Center to retain client's credit card information as listed below, and to charge client for services provided by Galloway Counseling Center in accordance with the Client Agreement including **counseling sessions, no-show sessions and sessions canceled within less than 24 hours of the scheduled session.** The Client Agreement is signed by client and on file with Galloway Counseling Center.

Please indicate your understanding and agreement of this Client Credit Card Authorization Agreement Form by signing this form in the space below.

Date: _____ Signature: _____

Print Name: _____

Credit Card Information: ☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **Amex**

Card # _____ **CVV:** _____

Name on Card: _____ **Expiration Date:** _____

Full Address of Cardholder: _____
Street/City State Zip code