CONSENT FOR SERVICES

I, _____, hereby give my full consent for _____ to receive services from Houston Family Therapy (HFT) until I notify HFT of any changes or until HFT determines services are no longer necessary.

I understand that I have the right to refuse services and to discontinue services at any time. Also, HFT may discontinue services for the following reasons: (1) the treatment goals of treatment have not been successfully met (2) two consecutive missed appointments without notification (3) three missed appointments within 60 days or (4) no contact with the therapist within 30 days after last appointment.

I understand I am financially responsible for counseling sessions as well as any court reports, appearances or consultations that are required in association with treatment received from HFT.

I understand there is an expectation — but no guarantee — that I/we will benefit from the services provided. There is also no guarantee regarding the duration of treatment. I understand sensitive and difficult topics, may be discussed in counseling that may bring up uncomfortable feelings/may lead to decisions that could be temporarily disruptive for my family and me.

I understand all information disclosed within my sessions is confidential and will not be revealed to anyone outside the therapist's supervision team without my written permission unless required by law. Disclosure may be required by law when (1) there is a reasonable suspicion of abuse/neglect to a child/teen, dependent or elder adult (2) the client communicates a threat of bodily injury to self or others (3) disclosure is required pursuant to a legal proceeding or (4) prenatal exposure to potentially harmful controlled substances is admitted.

HFT does not provide forensic evaluations, make recommendations about placement of a child/teen for custody disputes and does not provide investigation or reassessment to reach a determination about child abuse.

AUTHORIZATION TO SIGN ON A MINOR'S BEHALF

If the child/teen's biological parent(s) is not married (separated, divorced, etc.) or another person(s) has legal custody, a document showing authority to act on the child/teen's behalf is legally required to be filed in the client's chart.

I, _____, confirm that I am *(please check one):*

- ☐ The biological or adoptive parent having legal custody generally since birth, i.e. not separated or divorced (*no need to provide legal documentation*); or
- ☐ *The managing conservator; or
- ☐ *Other legal guardian and have been granted guardianship by the court or biological parents
  Please describe type: _____

**must provide legal documentation*

Signature of Parent/Guardian: _____ Date: _____

Signature of Client (13+ yrs old): _____ Date: _____

Signature of Clinician: _____ Date: _____

CONFIDENTIAL CLIENT/FAMILY HISTORY

The following information will be used to gain a better understanding of the client and develop a treatment plan. If a question does not apply, write "n/a" in the space provided. If you are unsure how to answer a question, put a question mark on the left and your therapist will help you.

CLIENT INFORMATION

Child's name: _____

Name of person completing form: _____ Relationship to client: _____

Preferred contact phone number: ( ) _____ Ok to leave message? YES NO

Client's birthplace: _____ Full date of birth: _____

EMERGENCY CONTACT

Name: _____ Relationship to client: _____

Preferred contact phone number: ( ) _____ Ok to leave message? YES NO

Alternate contact phone number: ( ) _____ Ok to leave message? YES NO

LEGAL PARENTS(S) / GUARDIANS

Name: _____ Relationship to client: _____

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

Preferred contact phone number: ( ) _____ Ok to leave message? YES NO

Other guardians: _____ Relationship to client: _____

Who else may bring the client to therapy? _____

CLIENT'S SCHOOL HISTORY

Current school: _____ Grade level: _____

Problems at school or with grades? YES NO UNSURE Learning disability? YES NO

Describe problems at school: _____

Who is your main contact at the client's school? _____

CLIENT'S BIRTH HISTORY

Please circle the applicable answer. If answering 'yes' to any question, please explain in the space provided.

Premature delivery	YES	NO	_____
Breathing problems	YES	NO	_____
Feeding problems	YES	NO	_____
Infections	YES	NO	_____
Prolonged hospitalization	YES	NO	_____
Other	YES	NO	_____

During pregnancy, did the client's biological mother use any of the following to the best of your knowledge:

Alcohol	YES	NO	_____
Illegal drugs	YES	NO	_____
Cigarettes	YES	NO	_____
Medications	YES	NO	_____

CONFIDENTIAL CLIENT/FAMILY HISTORY

DEVELOPMENTAL HISTORY OF CLIENT

Please place a mark in the box indicating your answer.

Motor Skills	**Early**	**Average**	**Late**	**Not Yet**
Sit alone	☐ Before 6 months	☐ Between 6-8 months	☐ After 8 months	☐
Crawl	☐ Before 8 months	☐ Between 8-11 months	☐ After 11 months	☐
Walk unassisted	☐ Before 11 months	☐ Between 11-15 mos	☐ After 15 months	☐
Speech				
Coo/make sounds	☐ Before 11 months	☐ Between 11-15 mos	☐ After 15 months	☐
Single words	☐ Before 15 months	☐ Between 15-18 mos	☐ After 18 months	☐
Words together	☐ Before 18 months	☐ Between 18-24 mos	☐ After 24 months	☐
Toilet training				
Bladder	☐ Before 24 months	☐ Before 2-3 years	☐ After 3 years	☐
Bowels	☐ Before 24 months	☐ Before 2-3 years	☐ After 3 years	☐

CLIENT'S SEXUAL DEVELOPMENT

Please circle the applicable answer. If answering 'yes' to any question, please describe in the space provided.

Reached puberty?	YES	NO	_____
Sexually active?	YES	NO	_____
Started menstruation?	YES	NO	_____
Started dating relationships?	YES	NO	_____

MEDICATION HISTORY OF CLIENT

Past medications: _____

_____

Present medications: _____

_____

Drug allergies: _____

_____

MEDICAL HISTORY OF CLIENT

Please circle if the client has had any of the following. Write the age at which it occurred and describe in the space provided.

Allergies	_____	Frequent headaches	_____
Asthma	_____	Heart Disease	_____
Broken bones	_____	Head injuries	_____
Cancer	_____	Sickle cell	_____
Diabetes	_____	Hospitalizations	_____
Epilepsy	_____	Other	_____

CONFIDENTIAL CLIENT/FAMILY HISTORY

CLIENT'S FAMILY HISTORY

Does the client or any of his/her biological relatives (including children in the family) have a history of the following:

☐ Alcohol abuse	_____	☐ Eating disorder(s)	_____
☐ Anxiety/nervousness	_____	☐ Hyperactivity	_____
☐ Depression	_____	☐ Learning disabilities	_____
☐ Developmental disorder	_____	☐ Physical violence	_____
☐ Domestic violence	_____	☐ Psychiatric problems	_____
☐ Drug abuse	_____	☐ Seizures	_____

ENVIRONMENT & BEHAVIORS OF CLIENT

Has the client or any family member ever been involved in abuse, neglect or with CPS? *(if yes, please describe)* _____

_____

Has the client or any family member been involved in dangerous activities, set fires, smeared feces or harmed him/herself or others? *(if yes, please describe)* _____

_____

Describe any circumstances that caused strain within the family during the client's first year of life such as illness, conflict or separation _____

_____

Have any stressful events or major changes happened that seriously affected the client's progress with sleeping, eating, acting out in school, etc? *(if yes, please describe)* _____

_____

Have any of your children lived outside the home before age 18? *(if yes, please describe)* _____

_____

Has the client or any family member been involved with legal problems (ex: guardianship, custody dispute, divorce, juvenile justice, incarceration, probation, etc.)? *(if yes, please describe)* _____

_____

What types of discipline do you currently use with your children, if any? _____

_____

CONFIDENTIAL CLIENT/FAMILY HISTORY

CLIENT'S MENTAL HEALTH

Has the client previously received mental health services? YES NO

If yes, what was the therapist/provider's name? _____

If prior services were received, what was the outcome? _____

_____

What do you see as the client's/your family's strengths? _____

_____

What religious or spiritual practices does the family participate in, if any? _____

_____

Is there any other important information about family mental health or social background you think we should know?

_____

Is there any other information about the client that is important for us to know? _____

_____

What is your main concern for seeking counseling services? _____

_____

What would you like the client and your family to get out of treatment? _____

_____

_____ _____

Signature of person completing form Date

Clinician has reviewed Confidential Client/Family History and has discussed any noteworthy information with the family.

_____ _____

Signature of clinician Date

INSURANCE, APPOINTMENTS, CANCELLATIONS, BILLING & CLIENT RIGHTS

INSURANCE POLICY

HFT does not accept insurance due to concerns about client confidentiality. These concerns include requirements of sharing records/treatment plans, limiting services/sessions and requiring diagnoses.

APPOINTMENT POLICY

For counseling to work, the client (and often his/her family) must be actively involved. This includes keeping scheduled appointments. As noted in the *Consent for Services*, HFT will discontinue services if (1) the treatment goals of treatment have not been successfully met (2) two consecutive missed appointments without notification (3) three missed appointments within 60 days or (4) no contact with the therapist within 30 days after last appointment.

CANCELLATION POLICY

It is your right to cancel appointments/therapy at any time. HFT requires 24 hours notice for appointment cancellations so others may benefit from the availability. If you do not cancel or appear at your scheduled time, you will be charged a full session fee.

BILLING INFORMATION

Payment is required at the time of service unless prior arrangements have been made. HFT requests you to keep a credit/debit card on file for late cancellations as well as no-show sessions; the full fee applies for both.

Name on card: _____

Type of card: □ American Express □ Discover □ MasterCard □ Visa

Card # _____ CVV Code: _____

Expiration date: _____ Billing zip code: _____

CLIENT RIGHTS ACKNOWLEDGEMENT

- I acknowledge that I received a copy of HFT's client rights.
- I acknowledge that my rights have been explained to me.
- I acknowledge that I have been given information regarding the reasons that counseling services may be involuntarily terminated by HFT.
- I acknowledge that I have been provided with information about what to do if I have a grievance with an HFT counselor.

Your signature below indicates your understanding and acceptance of HFT's insurance, appointment, cancellation, billing and client rights policies as well as your responsibility for paying your bill for counseling services. Your signature also authorizes HFT to charge the credit card listed above in the event of late cancellations (less than 24 hours notice) and no-show sessions.

_____ _____

Signature of person completing form Date

_____ _____

Signature of clinician/witness Date

CLIENT RIGHTS

I understand that as a Houston Family Therapy (HFT) client, I have the following rights:

- To the rights, benefits, responsibilities and privileges guaranteed by the Constitution, United States' laws and Texas laws, unless they have been restricted by specific terms of law
- To be treated fairly with dignity and respect without discrimination
- To receive the most appropriate services
- To confidential care and treatment
- To be informed of HFT's rules and hours, especially with regard to my behavior and what is expected of me
- To communicate in a language I understand
- To give input for my/my child's services and actively participate in the development and review of my/my child's treatment and discharge plans, where applicable
- To an explanation of benefits, effects, other choices and options, and risks of treatment
- To refuse or stop therapy services — without prejudice — and to receive an explanation of possible results of refusing, unless otherwise court ordered
- To meet with the person(s) treating me and receive an explanation of their education, training, title and responsibilities
- To request an in-house review of care, treatment and service plan
- To request — at my own expense — the opinion of an expert or consultant to review my services
- To an explanation of transferring my services to another mental health professional
- To receive information about the cost of my services
- To be asked if I agree to the use of one-way observation for clinical education/training purposes (ex: video or audio recordings or live feeds &/or photography)
- To my records being kept in a confidential manner though they are the property of HFT,
- To request access to my records or write an add-on in my record in accordance with HFT policy for such
- To be free from mistreatment, abuse, neglect and exploitation
- To have physical, emotional, developmental, educational, social, religious and spiritual needs met in relation to therapy
- To reasonable protection from theft/loss; note: HFT is not responsible for items stolen from vehicles parked on the premises
- To not be required to make public statements acknowledging my gratitude to HFT for services &/or outcomes
- To be given a copy of HFT's statement of Client Rights so I may review it, understand it and refer to it
- To an explanation of any rights that I do not understand
- To make a complaint about my services and rights without such complaints being used against me

COMPLAINTS: Contact the Texas State Board of Examiners of Marriage and Family Therapists — Complaints Management and Investigative Section at 800-942-5540 or PO Box 141369 (Austin, TX 78714).

RECORDS: My records &/or information conveyed to me/members of my family to HFT will not be released without my written permission unless required by Texas Law. While the information belongs to me as a client, the record belongs to HFT. The information will be protected by HFT, and HFT will retain the record under its possession for 7 years after termination of therapy services and 7 years after a minor client turns 18. Copies/transfer of the documentation within the record may be subject to fee.