University Counseling Center
William R Sheppard, D.Min., LPC, LMFT
1533 Merrimac Circle, Suite 101 Fort Worth, Tx 76107
Office # 817- 810-0030 Fax # 817- 877-3562 Web: http://www.uccsolutions.com

Patient's First Name:	
Patient's Middle Initial:	
Patient's Last Name:	
Preferred name or nickname:	
Patient's Gender:	○ Female ○ Male
Patient's Date of Birth (e.g. 7/4/1976):	Patient's Social Security #
Patient's Marital Status:	○ Single ○ Married ○ Other Spouse's Name:
Patient's Employment Status:	○ Employed ○ Full-Time Student ○ Part-Time Student ○ Other
Home Address (line 1):	
Home Address-line 2 (may be blank):	
City:	
State (e.g. "TX"):	
Zip Code:	
Home Phone Number (with dashes):	
Work Phone Number (with dashes):	
Work Extension, if any:	
Cell Phone Number (with dashes):	
Cell Phone Carrier:	○ AllTel ○ AT&T ○ Boost ○ Nextel ○ Sprint ○ SunCom ○ T-Mobile ○ Verizon ○ VoiceStream ○ Virgin ○ (Other)
Email address:	
How would you like appointment reminders to be sent to you?	○ Email (requires email address) ○ Text Message (requires cell number and carrier) ○ Phone call (requires home phone number) ○ None (no reminder will be sent)
Emergency Contact (name, relationship, number): *e.g. 'Sue and Joe Doe (parents) 214-555-1212*	

Create a "login name" (15 characters max, letters and numbers only) and a password (10 characters max, letters and numbers only) that you may use to make future appointments online. Please record them for future reference.	
Login Name:	
Password:	
If insurance will be used, please fill in the following. This is not a guarantee that your insurance coverage is accepted.	
Insurance Company:	
Insured Person's Name (usually the employee) Enter "last name, first name" e.g. "Doe, John P.":	
Patient's relationship to Insured Person:	○ Self ○ Insured's Spouse ○ Insured's Child ○ Other
Insured's Street Address:	
Insured's City:	
Insured's State (2 letters):	
Insured's Zip Code:	
Insured's Phone Number (with dashes):	
Insured's Date of Birth (e.g. 3/4/1956):	
Insured's Gender:	○ Female ○ Male
Employer (of the insured):	
I.D. Number (found on the insurance card):	
Group Number (if on insurance card):	
Insurance Phone No. (usually on card's back):	

REASON FOR SEEKING A THERAPIST

Change as a result of therapy is not guaranteed, but it is expected, disruption of life is not intended, but is usually necessary to effect change. The Therapist is trained to be an agent helping those who seek empowerment to make choices leading to change. The Therapist is committed to helping those seeking therapy in making those changes.

Briefly describe the main reason, which has brought you to counseling, and the outcome you desire:

Have there been any factors, events, or traumas contributing to you being here? Briefly explain:

Signature of Patient _____ ***Date:*** _____

Printed Name: _____

Revised 8-21-2012

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NOTICE OF PRIVACY PRACTICES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION EFFECTIVE APRIL 4, 2003

WHO DOES THIS NOTICE APPLY TO?

University Counseling Center provides health care in our clinic in partnership with other professionals and organizations. The following people will follow these privacy practices:

- ***Any University Counseling Center health care professional authorized to enter information into your chart.***
- ***All University Counseling Center departments and units.***
- ***Any member of a volunteer group that is authorized by University Counseling Center to help you.***
- ***All University Counseling Center employees, staff and other personnel.***
- ***Any business associate with whom University Counseling Center Shares health information.***

OUR PLEDGE TO YOU

We understand that medical information about you is personal. We are committed to protecting your private medical information. In an effort to provide the highest quality medical care and to comply with certain legal requirements, we will and are required to:

- ***Keep you medical information private.***
- ***Provide you with a copy of this notice***
- ***Follow the terms of this notice.***
- ***Notify you if we are unable to agree to a restriction you have requested.***
- ***Accommodate your reasonable requests to communicate health information by alternative means or at alternative locations.***
- ***Give you this notice of our legal duties and privacy practices with respect to your protected health information.***

CHANGES TO THIS NOTICE

We may change our policies and privacy practice at any time. Changes will apply to your protected health information we already hold, as well as new information obtained after the change occurs. When we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can receive a copy of the current notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice on the date of the first service delivery after April 14, 2003. You will also be asked to acknowledge in writing your receipt of this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

We may use and disclose your medical information for TPO (Treatment, Payment, Operations)

1. ***For your Treatment: such as sending medical information about you to a specialist as part of a referral.***
2. ***To obtain Payment for your treatment: such as sending billing information to your insurance company or Medicare.***
3. ***To support our healthcare operations: such as comparing patient data to improve treatment methods.***

EXAMPLES OF DISCLOSURE FOR TREATMENT, PAYMENT OR OEPRATIONS (TPO)

Subject to certain requirements, we may give out medical information about you without your prior authorization for the following purposes:

- ***Research: We may use and disclose medical information about you for research purposes. All research projects are subject to a special process through the appropriate committee.***
- ***Law: We may disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances or in response to valid judicial or administrative orders.***
- ***Public Health: We may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, disability, child abuse, or neglect, etc. as required by law.***
- ***Business Associates: There are some services provided in our organization through contracts with business associates, (i.e. We may disclosed medical information about you to a company who bills insurance companies to help us obtain payment for the health care services we provide). To protect your health information we require the business associate to appropriately safeguard your information.***
- ***Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care of your location and general condition.***
- ***We May Contact You: By phone, mail, and/or email, for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health-related benefits or services that may be of interest to you, or to support fundraising efforts, or a note to summarize about your counseling session, or inquire how you are doing.***
- ***Funeral Directors: We may disclose health information to funeral directors consistent with applicable law for them to carry out their duties.***
- ***Organ Donation: Consistent with applicably law, we may disclose health information to organ procurement organizations for the purpose of tissue donation and transplant.***

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- ***Food and Drug Administration (FDA):*** ***We may disclose to the FDA health information relative to adverse events.***
- ***Worker's Compensation:*** ***We may disclose health information necessary to comply with laws relating to Worker's Compensation or other similar programs established by law.***
- ***Correctional institution:*** ***Should you be an inmate of a correctional institution, we may disclose to the institution or its agents health information necessary for your health and the health and safety of other individuals.***
- ***State Requirements:*** ***Many states have requirements for reporting, including population-based activities relating to improving health or reducing health care costs.***

OTHER USES OF MEDICAL INFORMATION:

In any other situation not covered by this notice, we will ask you for your written authorization before using or disclosing your protected health information. If you choose to authorize our use or disclosure of your protected health information, you can later revoke and authorization by notifying us in writing of your decision.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

Although your health record is the property of the entity that created it, you have the right to:

- ***Request a restriction, in writing, on certain uses or disclosures of your medical information for treatment, payment or health care operations, with the exception of emergency situations. We will consider your request, but we are not legally required to agree to a requested restriction. We will inform you of our decision on your request.***
- ***Obtain a paper copy of this notice of our privacy practices upon request.***
- ***Inspect and obtain a copy of your medical information, in most cases.***
- ***Request in writing, an amendment to your records if you believe the information in your record is incorrect or important information was not created by us, maintained by us, or if we determined the record is accurate. You may appeal, in writing, a decision by us not to amend a record.***
- ***Obtain an accounting of disclosure stating who and where your health information has been disclosed for purposes other than treatment, payment, health care operations (TPO) or where you specifically authorized a use or disclosure in the past six (6) years, but not prior to April 14, 2003. The request must be in writing and state the time period desired for the accounting. After the first request, there may be a charge.***
- ***Request that medical information about you be communicated to you in a confidential way or at an alternative location but you must specify how or where you wish to be contacted.***

In the event that I, William Rob Sheppard, Retire, Close My Practice, or Die: ***You may contact in writing, University Counseling Center, Reva Sheppard, at 1533 Merrimac Circle, Suite 101, Fort Worth, TX 76107 for inquires or copies of your medical records. Currently, I am required to keep records on file for five (5) years, after treatment, for adults, and for a child's records, five (5) years after the child turns eighteen (18).***

By signing this form, I am consenting for William Rob Sheppard at University counseling Center to use and disclosure my medical information as disclosed in this Privacy Information Document.

Signature of Patient _____ ***Date*** _____

Printed Name of Patient _____

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Fee Schedule

90801	**INITIAL INTERVIEW**	**45 -50 Minutes**	**$150.00**
90843	**PSYCHOTHERAPY**	**20-30 Minutes**	**$ 60.00**
90806	**PSYCHOTHERAPY**	**45-50 Minutes**	**$125.00**
90846	**FAMILY THERAPY W/OPT**	**45-50 Minutes**	**$125.00**
90847	**FAMILY THERAPY W/PT**	**45-50 Minutes**	**$125.00**
90849	**MULTIFAMILY GROUP**	**45-50 Minutes**	**$150.00**
90853	**GROUP THERAPY**	**45-50 Minutes**	**$ 30.00**
	TELEPHONE CONSULTATION	**45-50 Minutes**	**$125.00**
	REQUEST FOR EXTENSIVE REPORTS		**$ 50.00**
	RETURNED CHECK FEE		**$ 35.00**
	COURT COST CHARGED BY DAY		**$1,000.00 day**

Performing as professional witness in court is not preferred. If called on or given a subpoena a retainer of $1500.00 is assessed plus $300.00 per hour spent in preparation time. The subpoena shall be turned over to my lawyer and any fees incurred by my lawyer shall be also billed in addition to the hourly rate of $300.00 per hour. Also I will need to cancel all my patient appointments on the day of the court day due to the unpredictability of court appointment times, therefore the fee is $1,000.00 for court days.

If you have insurance you pay the co-pay at the time of service and the full fee is required if the deductible is not met. If insurance denies payment it will be your responsibility to pay the fee for service.

Signature _____ ***Date*** _____

Printed Name of Patient _____

CLIENT RIGHTS: ***You, your family, and your friends can be assured that William R Sheppard and those affiliated with University Counseling Center want to protect your rights. We want to be sure that you receive all of your legal rights and that you are always treated with dignity and respect. Therefore, the purpose of this Client Rights statement is to inform you of your rights and obligations to William Sheppard and University Counseling Center as well as ours to you, in order to provide you the most effective treatment possible according to your needs.***

1. You have the right to considerate and respectful treatment, regardless of age, race, sex, national origin, citizenship or legal status.
2. You have a right to expect our staff to send you or refer you to other places for treatment if we do not, or cannot, offer you the services you need.
3. You have the right to be treated as a person capable or managing your own affairs if you are eighteen (18) years of age or older, unless a court orders otherwise.
4. You have the right to be fully advised of and question the fees charged by the University Counseling Center at the time of your intake process, classification and/ or throughout your services.
5. You have the right to know that your records are treated as confidential and cannot be released without our consent except under court order of law. Your records and private conversations with our staff will be kept in strict confidence, even after you stop coming here for services.
6. You have the right to get complete and current information concerning your treatment in terms, which you can understand. You have the right to know the name and title, professional qualifications of any person participating in your treatment.
7. You have the right to refuse treatment, except when limited by court order, law, or rule, and to be informed of the consequences of your refusal.
8. You have the right to request a written Individual Treatment Plan, as well as the right to participate in the preparation of the plan. In addition, you have the right to participate in the review and any changes to be made.
9. Whenever we ask you (or your parent or guardian) to make a decision about something, which affects you, you have the right to make your decision without force or pressure from us.
10. No one may take pictures of you or tape record in any program of University Counseling Center unless you agree in writing.
11. You have the right to speak up if you don't like your services, or if you think someone is taking away your right. You can tell a supervisor/administrator of University Counseling Center.

Signature _____ ***DATE*** _____

AFTER-HOURS EMERGENCIES: ***We do not provide 24-hour emergency service. In the event of an emergency go to the closest emergency room or call 911***

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INFORMED CONSENT, CONFIDENTIALITY & EMERGENCY, CANCELLATION POLICY, FINANCIAL ISSUES, COORDINATION OF TREATMENT, CONSENT FOR TREATMENT OF CHILDREN AND ADOLESCENTS

INFORMED CONSENT *This document is intended for you to give consent for mental health assessment, care, treatment to services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through William Rob Sheppard, therapist at anytime, but only with written consent. By signing this Patient information and Consent Form, I undersigned, patient, acknowledge that I have both read and understood all the terms and information contained herein. I have also read and received a copy of the, Notice of Privacy Practices and Client Rights document.*
Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

This document also is intended to inform you of our policies, State and Federal Laws and your rights. William (Rob) Sheppard is a Licensed Professional Counselor, and a Licensed Marriage and Family Counselor and also has a Doctorate of Ministry. He has over 20 years of clinical experience in treating adolescents, adults and families using individual and family therapy. William (Rob) Sheppard practices standard therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan interventions and risks will be discussed with you today. Therefore I consent to treatment.

Signature(s)_____ Date:_____

Printed Name_____

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or your child or children report about physical, sexual abuse, elder abuse, or abuse of a disabled person; then, by Texas State Law, I am required to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary they are to contact the emergency services in the community (911) for those services. William Rob Sheppard may be referred to for follow up of those emergency services with standard counseling and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential and I may not be able to respond.*

SUICIDE HOTLINE

24-Hour suicide prevention line that can be called from anywhere in the U.S.

1-800-SUICIDE	*1-800-273-TALK*	*1-800-799-4TTY (4889)*
1-800-783-2433	*1-800-273-8255*	*Deaf Hotline*

Signature_____ Date:_____

CANCELLATION / NO SHOW POLICY *I understand that it is important for me to be at all of my psychotherapy appointments. I understand and agree that if I cancel or fail to show up for Three (3) scheduled sessions, my therapist may use discretion regarding possible discharge. At that time, my therapist will contact the referring agency and my insurance company will be notified regarding the reason for discharge.*

Calling 24 hours in advance to cancel is required and appreciated by this facility. This allows us to utilize that time for other patients who may need an appointment. I understand that if I do not call within 24 hours to cancel my appointment, I will be charged a fee of what my insurance pays plus my co-pay; if I have no insurance I will pay the full $125.00 fee.
I also understand that if I am more than 15 minutes late for an appointment, rescheduling to a later time of a different day may be necessary. I understand I will be charged a fee of a missed appointment at the rate listed above.

Signature _____ Date_____

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FINANCIAL/INSURANCE ISSUES: ***As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $300.00 we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to William Rob Sheppard. I have received a copy of the fee schedule***

Signature(s)_____ Date_____

COORDINATION OF TREAMENT: ***It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent no information will be shared.***

____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE:_____

Signature(s)_____Date_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: ***I/We consent that (name of child or***

children)_____
may be treated as a client by William Rob Sheppard. I affirm that I have the legal independent right to consent to psychological treatment for this patient. I have submitted a copy of the court orders to William Rob Sheppard at University Counseling Center, if child is involved with divorce, separation, and or guardianship. It is understood that children have confidentiality protected by law. This consent to treat expires at the end of treatment or if revoked in writing.

Signature_____ Date_____

Printed Signature _____

Complaints
Any suspected violations of counselor ethics may be reported in writing to the following:
Complaints Management and Investigative Section
P. O. Box 141369 Austin, Texas 78714-1369
TX State Board of Examiners of Professional Counselors or TX State Board of Examiners of Marriage & Family Therapists

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