Patricia J. Gatlin, M.Ed.
Licensed Professional Counselor
Licensed Marriage & Family Therapist
990 N. Walnut Creek Drive, Suite 2017
Mansfield, TX 76063

Name: (First): ______________________________(Last):____________________________________(MI)__________

Address: ____Apt: ______________

City:_________________________________State: _____Zip: ___________ Email:________________________________

Telephone: (Work):________________________(Home):________________________(Cell): ______________________

May we leave a message at work? (Y N , at home (Y N) Date of Birth:____________________________

Social Security #: __________________________________Sex: M F Student Status: Yes No

Marital Status: (Married, Single, Widowed, Divorced, Other) ____

Emergency contact name/number ____

Primary Insurance Information (Please provide your insurance card so we may make a copy or email a picture of the card with these forms.)

Name of Insurance Company:____

Insured:____Relationship: ______________________________

Social Security #:____Date of Birth: ______________________

Identification Number:____Group Number: ____________________

Secondary Insurance Information

Name of Insurance Company: ____

Insured:____Relationship: ______________________________

Social Security #:____Date of Birth: ______________________

Identification Number:____Group Number: ____________________

Did the Insurance company/EAP give you an authorization number?__________________________________

Referral Information

Referred by: ____

(Primary Care Physician, Employer, Yellow Pages, Insurance Company, Other)

Employment Information (If we are filing your insurance claim)

Employer (of insured): ____

Address: ____

City: ______________________________ State: __________ Zip: ______________

Name of Insured: ____________________________ Relationship to client: ______________

Address: ____ Apt. ________

City: ______________________________ State: ______ Zip: ________________

Telephone: ____________________ Social Security #: ______________________

I verify that I have no other health coverage other than listed above ______________

(Initial here please)

ASSIGNMENT OF BENEFITS

I authorize payment of benefits directly to the above named professional for services.

Signed: ____________________________________ Date: __________________

RELEASE OF INFORMATION

I authorize the release (includes release by means of FAX) of any information necessary to process this claim.

Signed: ____________________________________ Date: __________________

If client is a minor, parent or guardian must sign below.

Signed: ____________________________________ Date: __________________

Patricia J. Gatlin, M.Ed., LPC, LMFT

NOTICE OF PRIVACY PRACTICES

This notice describes how counseling information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice take effect on the date signed and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF COUNSELING INFORMATION: The above named professionals collect health information from you and store it in a written form or computer record. This is your medical record. The medical record is the property of the treating professional. The information belongs to you. We use and disclose counseling information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your counseling information to a physician or other healthcare provider offering treatment to you.

PAYMENT: We may use and disclose your counseling information to obtain payment for services we provide for you.

HEALTHCARE OPERATIONS: We may use and disclose your counseling information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your counseling information for treatment, payment, or health operations, you may give us written authorization to use your counseling information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect.
Unless you give us a written authorization, we cannot use this information unless as described in this Notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your counseling information to you, as described in the Patients Rights section of the Notice. We may disclose your counseling information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your healthcare but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose counseling information to notify or assist in the notification of (including or locating) a family member, your personal representative, or another person responsible for you care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only counseling information that is directly relevant to the person's involvement in your healthcare.

MARKETING HEALTH RELATED SERVICES: We will not use your counseling information for marketing communications without your written permission.

REQUIRED BY LAW: We may use or disclose your counseling information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your counseling information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your counseling information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the counseling information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials counseling information required for lawful intelligence, counterintelligence and

other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your counseling information (i.e. name and phone number) to provide you with appointment reminders (such as voicemail messages, postcard of letters)

PATIENT RIGHTS: Access: You have the right to look at or get copies of your counseling information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (you must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending a letter to the address at the end of this Notice. If you request copies, we will charge you $30.00 for staff time to locate and copy your counseling information and postage if you're the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing you counseling information in that format. If you prefer, we will prepare a summary or an explanation of your counseling information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances if we disclosed your counseling information for purposes other than treatment, payment, or healthcare operations and certain other activities for the last 6 years, but not before March 17, 2006. If you request this accounting more than once in 12 month period we may charge you a reasonable, cost based fee for responding to these additional requests.

RESTRICTIONS: You have the right to request that we place additional restrictions on our use or disclose of your counseling information. We are not require to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency)

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your counseling information by alternative means or to alternate locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location.

AMENDMENT: you have the right to request that we amend your counseling information. (your request must be in writing and it must explain why the information should be amended) We may deny you request under certain circumstance.

ELECTRONIC NOTICE: If you receive this Notice on our Web site or by electronic mail (email) you are entitled to receive this Notice in written form.

QUESTION AND COMPLAINTS: If you want more information about our privacy practices or have questions or concern, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your access to your health information or in response to a request you made to amend or restrict the use or disclosure of your counseling information or to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services upon your request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

I acknowledge receipt of this information, and agree to the above conditions.

______________________________ ______________________________

Name of Patient or Representative **Date**

(Office use only)

If failure to obtain signature: Client

refused to sign___________

Client unable to understand due to language barrier_________

Contact information:

990 N. Walnut Creek Dr., Suite 2017

Mansfield, Texas 76063

Patricia Gatlin, M.Ed., LPC, LMFT, NCC
990 N. Walnut Creek Dr., Suite 2017 Mansfield, TX 76063
Cell: 817.676.4113; Email: Pgatlin@patriciagatlin.com

I am pleased that you have selected me as your counselor. This document is designed to inform you about my background and to ensure that you understand our professional relationship. I am a Licensed Professional Counselor, a Licensed Marriage and Family Therapist and a National Board Certified Counselor. I have two Masters' degrees—one in person-centered education and one in education school counseling, with additional graduate work in professional counseling and marriage and family therapy. I am trained through the EMDR Institute in eye movement desensitization preprocessing therapy, Gottman Couples Therapy, and I am a certified clinical hypnotherapist.

I believe that my role as a counselor is to facilitate clients as they explore ways to better understand themselves and be able to develop coping skills to adjust to situations that may arise in their environment and in their relationships with others. Being able to confront and understand our feelings and our thinking is important in becoming healthy and better enables us to more effectively tap into our strengths and act in ways that are beneficial to us. I believe that the job of the client is to fully participate and put forth effort in setting goals to improve relationships, situations, and thinking. You may end our counseling relationship at any point. If there is anything I am not able to help you with, I will provide you with references to other resources in order to give you the service you deserve. Honest communication is critical to an effective counseling relationship.

It is important that our relationship remain professional at all times rather than social, therefore, all communications will occur in the realm of the counseling sessions or logistics concerning counseling sessions. Your concerns are to remain confidential with the exception of professional consultations with a counseling team. Names and identifiable information will never be revealed in counseling team consultations. Your comfort with our relationship is of utmost importance to me, and I will respect your rights at all times. If social situations cannot be avoided, we will not ever discuss or refer to any concerns shared in counseling sessions, nor will we discuss that any counseling sessions are or have been taking place.

For children under 18 years of age, parents have a right to information concerning the progress of their child; however, the content of each session will be kept confidential in order to build rapport and trust with your child. Your child may want to include you in a session or have me share with you, however, please remember your child will be considered my client and their rights will receive primary consideration.

Anything shared during the counseling sessions will be kept confidential, with the following exceptions:

- You direct me to reveal information
- I determine you are a danger to yourself and others
- I am ordered by a court or state agency to disclose information
- You disclose knowledge of physical or sexual abuse to a minor
- You disclose sexual contact with another health professional

I assure you that I will work to provide services that are ethically standard as outlined in the American Counseling Association Code of Ethics and approved by the ACA Governing Council (2005).

Counseling session fees are $100.00 for a 45-minute session and $125 for a 60-minute session. Your insurance plan may cover this fee. If services are provided that are not covered by your insurance plan, you are expected to pay the cost of such services. If you are unable to attend a session, please contact me by phone or email. If you need to cancel your appointment, please notify my office via text, email, or phone at least 24-hours prior to your scheduled appointment time. If notification is not received at least 24 hours in advance, a $100 cancellation fee will be required.

If you have any questions, feel free to ask or contact me. I look forward to working with you. Please sign and date both copies of this form. Your signature indicates you have read and understand this statement and that you have the legal capacity to consent to this treatment for yourself and/or for those under your legal guardianship.

___________________________	___________________________
COUNSELOR	CLIENT SIGNATURE
___________________________	___________________________
DATE	DATE