Exult Healthcare
Integrated Behavioral Health

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

Client Name:

Date of Intake: Date of Birth:

Checklist for Intake	Initial
First Contact Sheet	
Client Information	
Patient History Form	
Consent to Treat	
UDS Test Result Form	
Release of Health Information	
Medication List	
Receipt of HIPPA agreement	
Patient Bill of Rights	
Complaint and Grievance Process	
Modified Mini Screen	
EAT-26	
GAD-7	
Copy of Credit Card on file (by date)	
Copy of Divorce Decree (if applicable)	
Cope of insurance card and driver's license	
Signed copy of therapy pricing and services	
Receipt of Handbook	
Financial agreement for all IOP's and therapy sessions	

Date of Chart Audit	Completed By	Signature

Exult Healthcare
Integrated Behavioral Health

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

Client Information

Personal Details

Date: _____ Name: _____ DOB:_____ Age:_____

Address: _____

Ssn:_____ Wk Phone:_____ Cell: _____

Email: _____ Employer/School:_____

Sex [ ] Male [ ] Female

Marital Status: [ ]Single [ ]Married [ ]Separated [ ]Divorced [ ]Widowed

My Primary Care Physician Is:_____

My Last Physical Was:_____

Primary Insurance

Insurance: _____ Policy/Member ID: _____ Group#:_____

Insurance Holder(Name):_____ DOB:_____ SSN:_____

Relationship to Client:_____

Secondary Insurance

Insurance: _____ Policy/Member ID: _____ Group#:_____

Insurance Holder(Name):_____ DOB:_____ SSN:_____

Relationship to Client:_____

I,_____, have provided the above information accurately and to the best of my knowledge. It is my responsibility to notify Exult Healthcare's office of any changes of insurance or demographic information. I understand the payment of co-pay/co-insurance, are due before any services are rendered. I certify that I, and/or my dependents have insurance coverage, and I assign directly to Exult Healthcare all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named company/ies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the signed below date.

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone:_____

Address:_____

_____ _____
(Signature of Patient or Guardian) (Date)

Exult Healthcare
Integrated Behavioral Health

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

Patient History Form

Date:_____ Patient Name:_____ DOB:_____

Chief Complaint:

History of Present Complaint:

Past Psychiatric History (diagnosis, symptoms and onset):

Family Psychiatric History (Describe if any):

Exult Healthcare
Integrated Behavioral Health

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

History of Medical Illness:

O None	O Thyroid Disorder	O Chronic Bronchitis	O Diabetes
O Cancer	O Epilepsy	O Heart Disease	O Asthma
O Anemia	O Hepatitis	O Liver Disease	O Kidney Disease
O Insomnia	O Sleep Apnea	O Headaches	O Lung Problems
O Constipation	O Vertigo	O Over-Eating	O Anorexia/Bulimia
O Glaucoma	O Stroke	O Fatigue	

O Allergies _____

How well do you sleep? _____

How many hours do you sleep? _____ How many meals per day? _____

Have you had a history of physical/sexual/emotional abuse:	O Yes	O No
Have you been in the military:	O Yes	O No
If so, did you see combat:	O Yes	O No
Have you been through a traumatic event:	O Yes	O No

What has been your most significant relationship?

What are some common stressors?

Do you do any self-harm like cutting, burning, picking	O Yes	O No
Are you currently having suicidal ideations:	O Yes	O No
If so, do you have plan:	O Yes	O No
Do you have intent:	O Yes	O No

Exult Healthcare
Integrated Behavioral Health

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

Have you ever attempted suicide: O Yes O No

If yes: Number of times: _____ Date/s: _____

Have you ever seen a counselor, therapist, psychologist or psychiatrist? O Yes O No

If yes describe (include name and dates):

Have you ever been hospitalized for Psychiatric or Chemical Dependency issues: O Yes O No

If yes describe (include facility and dates):

How frequently have you used the following (Please Circle):

Marijuana	Never	Once	Sometimes	Always
Alcohol	Never	Once	Sometimes	Always
Tobacco	Never	Once	Sometimes	Always
Amphetamines	Never	Once	Sometimes	Always
Opiates	Never	Once	Sometimes	Always
Cocaine	Never	Once	Sometimes	Always
LSD/PCP	Never	Once	Sometimes	Always
Mushroom	Never	Once	Sometimes	Always
Synthetic drug (ex. ecstasy, K2, bath salts)	Never	Once	Sometimes	Always
Benzodiazepines (ex. Xanax, Clozapine)	Never	Once	Sometimes	Always
Barbiturates	Never	Once	Sometimes	Always

Client's Signature: _____ Date:_____

Exult Healthcare Signature: _____Date: _____

Exult Healthcare
Integrated Behavioral Health

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

Consent to Treat

I, _____, am giving Exult Healthcare and my provider,_____, consent to treat either myself or someone in my legal guardianship.

About My Provider

All of our therapist are licensed and specialized in helping you understand and guide you through your mental health journey. We offer different experience levels from LPC-S to LPC-I. Your therapist will let you know their credentials before your initial session to help you decide which avenue to take.

Client/Therapist Relationship

The relationship between the therapist and client is a professional relationship existing only for therapeutic treatment. The therapeutic relationship works when remaining strictly professional and only in therapeutic means. Gifts are not appropriate, nor is any trade for service.

Services:

Exult Healthcare is an integrated behavioral healthcare facility. Exult offers different modalities of mental health such as but not limited to: individual therapy, group therapy, pet therapy, family therapy, play therapy, intensive outpatient, support groups, transcranial magnetic stimulation (TMS), weight loss management, psychiatry services, medication management, and yoga. All of our services are staffed by licensed professionals who work for your mental health. It is our purpose to convey the policies and procedures used in our practice and we will always discuss questions or concerns.

Confidentiality

We understand that there are reasons of mental health that brought you to Exult Healthcare and our providers will help you understand and discuss the reasons. For our team of licensed professionals, the client needs to disclose information that pertains to their needs.

The Health Insurance Portability and Accountability Act (HIPPA) enacted by the United States Department of Health and Human Services protect the things you share with your provider under the confidentiality laws of the State of Texas. Neither verbal information nor written records about a client can be shared with another party without the written consent of the client or the client's legal guardian.

There are however limits to confidentiality that you should know about before we begin therapy. Those exceptions include:

- Signed authorization from you to release information to a specific individual or organization
- Therapist determination that you may harm yourself or someone else
- Disclosure of abuse, neglect, or exploitation of a child, the elderly, or the disabled
- Disclosure of professional misconduct of another mental health professional
- Court order or requirement by law to disclose information
- Pre-natal exposure to controlled substances
- In the event of a client's death (the spouse or parents of a deceased client may have the right to access their child's or spouse's records)
- Minors/Guardianship (parents or legal guardians of non-emancipated minor clients have the right to access the client's records)
- Insurance Companies (only information required for billing purposes)

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

Sessions

We will devote our sessions, usually 45-50 minutes to helping you find new ways to help yourself. Our efforts will always be legal, ethical, and relevant, and might be carried out within our sessions as well as without, in the form of homework. It's hard to predict how many sessions will be needed to bring about the changes you want. If you like, your provider can discuss further with you how many sessions they may think it will take to reach your goals, after they become more familiar with your background.

Therapy and all therapeutic relationships between client and therapist is strictly a professional one and not a social one. It is also discouraged to offer therapists gifts or ask to join in any social event other than a professional context.

Please note that it is not possible for our providers to guarantee any specific result or outcome regarding your counseling goals. That will depend on your progress and willingness to make changes in your life and behavior. We will however, work closely with you to achieve the best possible results.

Legalities

Exult Healthcare is committed to providing therapeutic care and your relationship with your provider is strictly therapeutic and not legal. Because of the nature of the therapeutic relationship it may not be in your best interest to engage your provider in legal or forensic services. The core practices at Exult Healthcare do not include legal or forensic services.

As such, I hereby acknowledge, understand, and agree that in the event that any provider or staff member of Exult Healthcare is subpoenaed, summoned, noticed, or in any way requested or commanded to give testimony, produce records, appear, or in any way be involved in any type of legal proceeding, that the therapeutic relationship will be considered immediately terminated. At the time, Exult Healthcare will no longer provide counseling or related therapeutic services, but will fulfill court mandated legal obligations on a factual or forensic basis.

You consent that if you, or any person that was present during any counseling or therapy session, subpoenas, summons, notices, or in any way requests or commands any provider or staff member of Exult Healthcare to give, testimony, produce records, appear, or in any way be involved in any type of legal proceeding, that such subpoena summons, notice, or other request will been deemed invalid and void until, unless: (1) the retainer fees for Exult Healthcare's provider have been secured and (2) a HIPAA authorization to release information form has been filled out and signed by ALL parties that have been present during any counseling or therapy session.

Electronic Communication Policy

You are solely responsible for any risks associated with any electric communication and agree that Exult Healthcare and its providers are not responsible for any breach of confidentiality that may ensue as a result of your choice for engagement:

Email

Please only email Exult Healthcare staff administration for reasons only to modify appointments, billing information, etc. Please remember that any information disclosed in these emails are not secured or confidential and any emails sent may become a part of your mental health record.

Texting

Please do not send text messages to any providers. Please remember that any information disclosed in these texts are not secured or confidential and any texts sent may become a part of your mental health record.

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

Faxes

Please remember that any information disclosed in these faxes are not secured or confidential and any faxes sent may become a part of your mental health record.

Emergency

Exult Healthcare is not an emergency center and if you are looking for emergency or immediate help, please call 911 immediately. If you are in a personal crisis or need to see your Exult Healthcare provider, please call the front office to set up an appointment and the next available licensed professional will provide you with assistance or additional resources.

Client Rights

It is your right at any time to inquire about the process and procedures being used during our counseling relationship. You have the right to refuse or negotiate modifications of any of our suggestions.

We assure you that our services are rendered in a professional manner consistent with ethical standards set forth by the below listed boards of examiners. If for any reason you believe our services are unethical, please let us know. If we are unable to resolve these concerns, you may report your complaints to the below regulatory agencies: (Please note the first four boards have the same mailing address).

Texas State Board of Examiners of Professional Counselors - Telephone: (512) 834-6658
Texas State Board of Examiners of Marriage and Family Therapists - Telephone: (512) 834-6657
Texas State Board of Social Worker Examiners - Telephone: (512) 719-352
Texas Licensed Chemical Dependency Counselor Program - (512) 834-6605
Texas Department of State Health Services
Mail Code 1982
P.O. Box 149347
Austin, Texas 78714-9347

Right to Withdraw from Treatment

If a conflict arises for the client or the provider, either has the right to withdraw from the treatment process. If the provider feels the need to withdraw from providing treatment, she or he will inform the client and provide appropriate referrals and 30-day emergency care.

INTIAL:_____

Phone Consultations

We provide phone consultations in lieu of regular follow ups. The cost of this service is $150. In understand that these consultations are not billable to my insurance carrier. The practice reserves the right of charging $25 for every 15 minute of staff time.

INITIAL: _____

Interruptions In Service

If an unforeseen event occurs (such as a serious illness or death etc.), which renders your therapist unable to provide services, a referral will be made until the therapist is able to return to work.

INITIAL:_____

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

Records

If you need a copy of your medical record, you must give this office a signed notification from the client and a two week notice. The charge for medical records is $50.00 for first 50 pages and .50 cents for every page after. Records are stored for seven years per legal requirements.

INITIAL:_____

Forms, Letters Request

You will be responsible for cost of completion of forms. The fees may vary depending on amount of time in preparing and processing the forms. The rate varies from $150 to $300.

INITIAL:_____

Language/ Culture

If cultural or language differences may negatively impact prospects of successful treatment, you may ask for a referral to a provider of your culture or who speaks your language. Your provider will assist in such a referral if one can be found.

INITIAL:_____

Danger

In the event that your therapist, in her clinical judgement believes you to be dangerous to yourself or to someone else, by signing this consent you authorize her or him to contact either the person listed as your emergency contact to provide assistance through this crisis situation.

INITIAL:_____

Appointments

If you need to cancel an appointment, a 24-business notice is required. If you miss or cancel an appointment without a 24-business hour notice, you will be charged $75.00 for the missed appointments can not be filed with insurance. Therefore, your are solely responsible for the entire fee.

INITIAL:_____

Returned Checks

There is a $50.00 charge for any returned checks.

INITIAL:_____

Fee Schedule and Insurance

The following private pay fee schedule of Exult Healthcare is disclosed for your information:

Initial Visit	$250
Regular Visits/ Follow-Ups (individual, couple, ect.)	$185
Written Reports (Forms, Letters, and Report Requests)	$150-$300
No-Show (Less than 24 hours advance cancellation)	$75
Record Fees (first 20 pages and .50 cents per page after)	$50
Returned check fee per check	$50
Credit Card dispute processing and jurisdiction fee	$300
Legal Proceedings and Services by provider (per hour)	$400
Legal Proceedings and Services preparation by staff(per hour)	$75
Phone Consultation(for every 15 minutes)	$25

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

Please note and be informed that in the event payments for services rendered have not been collected. Exult Healthcare reserves the right to report any and all uncollected portion of balances to a collections agency, attorney, and/or legal authority. Also, please be informed that any fees incurred by Exult Healthcare on your behalf, for ANY collection, legal services, or otherwise, are your direct responsibility.

By consenting to treatment, you acknowledge that you are responsible for the cost of these services provided to you or your minor child and agree to pay them when billed or at time or service. If services are not paid, then you agree to pay a service charge as well as any finance charge that may apply. After 90 days, the account may be assigned to a collections agency, in which case you will be responsible for paying attorney fees and/or collection fees and expenses. Outstanding balances past 90 days will be charged $50.00 collection fees.

INITIAL:_____

It is important that if you choose to utilize your insurance, we will be obligated to provide them certain information about your case including but not limited to diagnosis, type and dates of services. By assigning benefits to Exult Healthcare you are authorizing them to provide your insurance carrier or their intermediary whatever information is necessary to process the claim. If you choose to utilize your insurance it may affect your insurability in the future. If at any time you have questions about the fees or insurance, please feel free to discuss them with the staff.

I understand that the practice will, as a courtesy to me, file on my behalf. I understand and agree that I am ultimately responsible for an any and all fees not covered by my insurance carrier. I understand that my insurance policy is a contract between my insurance company and me and therefore will not hold Exult Healthcare for denial of coverage or for negotiating claims with the insurance company and the insurance company and other individuals. I agree that copays and non-covered services are payable at the time of service unless other arrangements have been made. In the event that my insurance carrier declines my benefits, I acknowledge and agree that I am fully responsible for the declined charges and can expect them to be applied to my account and charged to my credit card on file.

INITIAL:_____

Termination of Services

I understand and agree that I am entering into a therapeutic relationship with my provider. The success of the treatment is contingent upon active participation and constant attendance. More than three no shows may result in termination of services. Your file may be closed after 60 days of no communication and no appointments.
*Therapy is a process that allows you the freedom and privacy to discuss issues that are often painful or difficult to discuss with family and/or friends.*The following are a few suggestions to help make your counseling experience most effective:

1. Before your scheduled appointment, write down questions, topics, or issues you would like to focus on in your session.
2. Communicate your expectations to our providers so that we are working together towards your goals.
3. Provide ongoing feedback to your provider so that they know how you are doing (example, "I want to focus on my anger more" or "I like doing relaxation exercises").
4. If you feel a need to increase or decrease the frequency of your sessions, or to end counseling, feel free to communicate that to your counselor/ therapist.
5. If you feel a need to bring a partner, relative, or friend in with you for your session in order to work on interpersonal issues, feel free to do so. Please discuss it with your provider prior to their arrival.
6. If you have another professional involved in your care (i.e. physician, chiropractor, attorney, etc.), we would be happy to coordinate with him/her if you wish. It is not advisable to have more than one mental health counselor involved in your treatment at one time.

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

8. If for any reason you would like to see a different therapist, please feel free to tell our office. We can either provide you with another provider within our facility or recommend to you other therapists in the area.

INCAPACITY OR DEATH: I understand that, in the event of termination of contract, personal emergency, death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

INITIAL:_____

Electronic Signatures

I agree that if this agreement or related documents are signed when party's signature are delivered by fax, email, or any other electronic medium. These signatures are and must be treated in all respects as having the same force and effect as original signatures.

INITIAL:_____

My signature below affirms that I have read and understood this agreement and office policies of Exult Healthcare, I acknowledge that all of my questions have been fully answered. I further acknowledge, understand, and agree that such terms may be amended from time to time to meet the needs of the practice.

Name of Responsible:_____

Signature:_____ Date: _____

Witness Signature:_____ Date:_____

Risk of Using Email/Texts/Fax
The transmission of client information by email, faxes, and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

a. Email, faxes, and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b. Email, fax, and text senders can easily misaddress an email, fax, or text and send the information to an undesired recipient.
c. Backup copies of emails, faxes, and texts may exist even after the sender and/or the recipient has deleted his or her copy.
d. Employers and online services have a right to inspect what is sent through their company systems.
e. Emails, faxes, and texts can be intercepted, altered, forwarded or used without authorization or detection.
f. Emails, faxes, and texts can be used as evidence in court.
g. Emails, faxes, and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the Use of Email, Faxes, and Texts
Provider cannot guarantee but will use reasonable means to maintain security and confidentiality of email, fax, and text information sent and received. Provider is not liable for improper disclosure of confidential

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

information that is not caused by provider's intentional misconduct. Clients /Parent's/Legal Guardians must acknowledge and consent to the following conditions:

a. Email, fax, and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email, fax, and/or text will be read and responded to within any particular period of time. Email, fax, and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.

c. All emails and faxes will usually be printed and filed into the client's medical record. Texts may-be printed and filed as well.

d. Provider will not forward client's/parent's / legal guardian's identifiable emails, faxes, and/or texts without the client's/parent's/legal guardian's written consent, except as authorized - by law. Provider is not liable for breaches of confidentiality caused by the client or any - third party.

e. Clients/parents/legal guardians should not use email, fax or text for communication – of sensitive medical information.

g. It is the client's/parent's / legal guardian's responsibility to follow up and/or schedule - - an appointment if warranted.

I,_____, certify that the following person(s) can receive, send, or communicate on my behalf.
The following person(s) may send, receive or communicate on my behalf:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Patient Name:_____ Date of Birth:_____

Patient Signature:_____ Date:_____

Parent of Legal Guardian:_____

Patient Communication Consent Form

I agree to allow Exult Healthcare to contact me in the following methods regarding my private health information and general information regarding the practice.

Method	Number/Address	Message (yes or no)	
[ ] Home Phone	_____	[ ] Yes	[ ] No
[ ] Work Phone	_____	[ ] Yes	[ ] No
[ ] Cell Phone	_____	[ ] Yes	[ ] No
[ ] Voice Mail	_____	[ ] Yes	[ ] No
[ ] Text Messages	_____	[ ] Yes	[ ] No
[ ] Email	_____	[ ] Yes	[ ] No
[ ] Physical Mail	_____	[ ] Yes	[ ] No

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

If you have read and understand these aspects of consent, please sign below. If you would like a copy of this consent form, for your records, Exult Healthcare will be happy to provide you with one. If you have any questions about any of the information on this form, discuss them with your provider and wait to sign the form. Insurance questions may be addressed by Exult Healthcare. By signing this form, you acknowledge that all questions have been fully answered and you agree to terms of this agreement.

INITIAL:_____

Exult Healthcare is committed to providing high quality services and all the information necessary to be informed about the treatment process. If you agree to the stipulations, please initial in all sections and sign the last page of this form as you consent to treatment. Exult Healthcare maintains personnel and facilities in order to provide medical/psychiatry/therapeutic care. By consenting to this treatment agreement, I authorize the staff to provide services in office via telephone, tele-psychiatry. The consent is applicable to all providers at Exult Healthcare services can be rendered by different providers based on availability.

INITIAL:_____

Client Acknowledgement and Agreement
I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email, fax, and/or texts between my provider and me, and consent to the conditions and instructions outlined, as well as any other instructions that my provider may impose to communicate with me by email or text. I understand the risk associated with the different methods of communication (especially e-mail and texting), and consent to the conditions, restrictions, and patient responsibilities.

Client Name:_____

Signature:_____ Date:_____

Parent/Legal Guardian Name:_____

Signature:_____ Date:_____

Provider Name:_____

Signature:_____ Date:_____

Exult Healthcare
Integrated Behavioral Health

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

UDS Test Results

Client's Name: _____

Address: _____

Phone: _____

D.O.B: _____

Date Of Testing: _____

Administered by: _____

Read by: _____

Drug Name	Symbol	Negative	Confirm	N/A
Amphetamine	AMP			
Secobarbital	BAR			
Buprenorphine	BUP			
Oxazepam	BZO			
Cocaine	COC			
Methylenedioxymethamphetamine	MDMA			
Methamphetamine	MET/mAMP			
Morphine	MOP			
Methadone	MTD			
Opiate	OPI			
Oxycodone	OXY			
Phencyclidine	PCP			
Propoxyphene	PPX			
Notriptyline	TCA			
Cannabinoids	THC			

Actions Taken:

Authorization to Use, Disclose, or Release Health Information

Exult Healthcare
Integrated Behavioral Health

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

Patient Name:_____ Date of Birth:_____

Address:_____ Telephone:_____

I authorize my [ ] Primary Care Physician, [ ] Psychiatrist, [ ] Therapist, [ ] or any other health care provider.

Name:_____ Phone Number:_____ Fax Number: _____

They are able to disclose or release my protected health information to Exult Healthcare.

The protect information to be released is as follow(s):

[ ] History and Physical
[ ] Discharge Summary
[ ] Lab Results
[ ] Progress Notes
[ ] Operative Report
[ ] Pathology Report
[ ] X-Ray Imaging Records
[ ] Entire Chart

[ ] Other specify what is to be used, disclosed, or released): _____

[ ] All Records Allowed

I understand that the information to be disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

Signature:_____ Date:_____

DATE	FAXED TO	FAX NUMBER	BY	RECEIVED

CURRENT MEDICATION

Client Name:_____

Client Date of Birth: _____

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

DATE	MEDICATION NAME	STRENGTH	FREQUENCY	PURPOSE	PHYSICIAN	DATE STARTED	DATE DISCONTINUED

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 (PHJ) 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 he alt h information. "Protected health information" is information about you, including demographic

information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health services.

I. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff 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 physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, a necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure 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 may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name when your physician 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. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceeding s: Law Enforcement: Coroners , Funeral Director s, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the regulations of Section 164.5 00.

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to issue and copy your protected health information. Under Federal Law, however, you may not inspect or copy the following records; psychotherapy notes , information compiled in reasonable anticipation, or in use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply

Your physician is not required to agree to a restriction that you may request. If your physician believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative mean means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

3. Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contract of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____

Signature: _____ Date: _____

Patient Bill of Rights

The facility shall respect, protect, implement, and enforce each patient right required to be contained in the facility's Patient Bill of Rights. The Patient Bill of Rights for all facilities shall include:

(1) You have the right to accept or refuse treatment after this explanation.
(2) If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law).

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

(3) You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
(4) You have the right to be free from abuse, neglect, and exploitation.
(5) You have the right to be treated with dignity and respect.
(6) You have the right to appropriate treatment in the least restrictive setting available that meets your needs.
(7) You have the right to be told about the program's rules and regulations before you are admitted, including, without limitation, the rules and policies related to restraints and seclusion. Your legally authorized representative, if any, also has the right to be and shall be notified of the rules and policies related to restraints and seclusion.
(8) You have the right to be told before admission:
  (a) The condition to be treated;
  (b) The proposed treatment;
  (c) The risks, benefits, and side effects of all proposed treatment and medication;
  (d) The probable health and mental health consequences of refusing treatment;
  (e) Other treatments that are available and which ones, if any, might be appropriate for you; and
  (f) The expected length of stay.
(9) You have the right to a treatment plan designed to meet your needs, and you have the right to take part in that plan.
(10) You have the right to meet with the staff to review and update the plan on a regular basis.
(11) You have the right to refuse to take part in research without affecting your regular care.
(12) You have the right to not receive unnecessary or excessive medication.
(13) You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
(14) You have the right to be told in advance of all estimated charges and any limitations on the length of services in which the facility is aware.
(15) You have the right to receive an explanation of your treatment or your rights if you have questions while you are in treatment.
(16) You have the right to make a complaint and receive a fair response from the facility within a reasonable amount of time.
(17) You have the right to complain directly to the Texas Commission on Alcohol and Drug Abuse at any reasonable time.
(18) You have the right to get a copy of these rights before you are admitted, including the address and phone number of the Texas Commission on Alcohol and Drug Abuse.
(19) You have the right to have your rights explained to you in simple terms, in a way you can understand, within 24 hours of being admitted.

By signing this statement, I acknowledge that I have received this notification of my rights and that they have been explained to me in a way which I understand. I have been given the opportunity to have any questions pertaining to this document answered to my satisfaction and have received an additional copy for my own records.

Client's Signature: _____ Date:_____

Exult Healthcare Signature: _____Date: _____

Complaint and Grievance Process

If, at any time, you or a family member believe that your treatment at Exult Counseling's Program is not adequate, safe or in your best interest, you have the following rights, which will not in any way serve to compromise your future access to care:

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

1. You have the right to voice your complaint expressing your concern about the quality of care you receive.
2. You may seek remedy for any complaint.
3. You may complain directly to any staff member.
4. You may submit the complaint in writing and may have assistance in writing the complaint if you are unable to read or write.
5. Staff will initiate an investigation of your complaint within 72 hours of receipt of the complaint and provide you with a written response to the complaint within seven days.
6. You may request direct access to the Director at some time during the grievance process.
7. If you believe any of your rights have been violated or you have other concerns about your care in this facility, you may contact one or more of the following:

Texas State Board of Examiners of Professional Counselors
Telephone: (800) 832-9623
MC1982
PO BOX 141369
Austin, TX 78714-1369
Telephone: (800) 942-5540

Substance Abuse Facility Investigations (MC 1979)
Texas Department of State Health Services
P.O. Box 149347
Austin, TX 78714-9347
Telephone: (800) 832-9623

By signing this statement, I acknowledge that I have received this notification of my rights and that they have been explained to me in a way which I understand. I have been given the opportunity to have any questions pertaining to this document answered to my satisfaction and have received an additional copy for my own records.

Client Name-Print:_____ Date: _____

Client Signature:_____ Date: _____

Witness Name-Print:_____ Date: _____

Witness Signature:_____ Date: _____

Modified Mini Screen (MMS)

Patient Name _____ Date: _____

Interviewer _____

Exult Healthcare
Integrated Behavioral Health

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

SECTION A – Please circle "yes" or "no" for each question.

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past 2 weeks?	Yes	No
2. In the past 2 weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?	Yes	No
3. Have you felt sad, low or depressed most of the time for the last two years?	Yes	No
4. In the past month, did you think that you would be better off dead or wish you were dead?	Yes	No
5. Have you ever had a period of time when you were feeling up, hyper or so full of energy or full of yourself that you got into trouble or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.)	Yes	No
6. Have you ever been so irritable, grouchy or annoyed for several days, that you had arguments, verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way?	Yes	No
PLEASE TOTAL THE NUMBER OF "YES" RESPONESES TO QUESTION 1-6		

SECTION B – Please circle "yes" or "no" for each question.

7. Not this question is in 2 parts. a) Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable or uneasy even when most people would not feel that way? YES NO b) If yes, did these intense feelings get to be their worst within 10 minutes? YES NO If the answer to BOTH a and b is YES, code the question YES. If the answer to either or both a and b is NO, code the question NO	Yes	No
8. Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult? Examples include: ‰ Being in a crowd	Yes	No

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

‰ Standing in a line ‰ Being alone away from home or alone at home ‰ Crossing a bridge ‰ Traveling in a bus, train or car		
9. Have you worried excessively or been anxious about several things over the past 6 months? If no to Question 9, answer "no" to Question 10 and proceed to Question 11.	Yes	No
10. Are these worries present most days?	Yes	No
11. In the past month, were you afraid or embarrassed when others were watching you, or when you were the focus of attention? Were you afraid of being humiliated? Examples include: ‰ Speaking in public ‰ Eating in public or with others ‰ Writing while someone watches ‰ Being in social situations	Yes	No
12. In the past month, have you been bothered by thoughts, impulses, or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive or distressing? Examples include: ‰ Were you afraid that you would act on some impulse that would be shocking? ‰ Did you worry a lot about being dirty, contaminated or having germs? ‰ Did you worry a lot about contaminating others, or that you would harm someone even though you didn't want to? ‰ Did you have any fears or superstitions that you would be responsible for things going wrong? ‰ Were you obsessed with sexual thoughts, images or impulses? ‰ Did you hoard or collect lots of things? ‰ Did you have religious obsessions?	Yes	No
13. In the past month, did you do something repeatedly without being able to resist doing it? Examples include: ‰ Washing or cleaning excessively ‰ Counting or checking things over and over ‰ Repeating, collecting, or arranging things ‰ Other superstitious rituals	Yes	No
14. Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples includes ‰ Serious accidents ‰ Sexual or physical assault ‰ Terrorist attack ‰ Being held hostage ‰ Kidnapping ‰ Fire ‰ Discovering a body ‰ Sudden death of someone close to you ‰ War ‰ Natural disaster	Yes	No

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

15. Have you re-experienced the awful event in a distressing way in the past month? Examples include: ‰ Dreams ‰ Intense recollections ‰ Flashbacks ‰ Physical reaction	Yes	No
PLEASE TOTAL THE NUMBER OF "YES" RESPONESES TO QUESTION 7-15		

SECTION C – Please circle "yes" or "no" for each question.

16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?	Yes	No
17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?	Yes	No
18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed?	Yes	No
19. Have you ever believed that you were being sent special messages through the TV radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you?	Yes	No
20. Have your relatives or friends ever considered any of your beliefs strange or unusual?)	Yes	No
21. Have you ever heard things other people couldn't hear, such as voices?	Yes	No
22. Have you ever had visions when you were awake or have you ever seen things other people couldn't see?	Yes	No
PLEASE TOTAL THE NUMBER OF "YES" RESPONESES TO QUESTION 16-22		

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

Scoring the Section

NUMBER OF "YES" RESPONSES FROM SECTION A	
NUMBER OF "YES" RESPONSES FROM SECTION B	
NUMBER OF "YES" RESPONSES FROM SECTION c	
TOTAL NUMBER OF "YES" RESPONSES FROM SECTIONS A, B & C	
YES RESPONSE TO QUESTION #4	
YES RESPONSES TO QUESTIONS #14 AND #15	

Binge Eating Disorder Screener-7 (BEDS-7)

Instructions:
If the patient answers "YES" to question 1, continue on to questions 2 through 7. If the patient answers "NO" to question 1, there is no reason to proceed with the remainder of the screener.

If the patient answers "YES" to question 2 AND checks one of the shaded boxes for all questions 3 through 7, follow-up discussion of the patient's eating behaviors and his or her feelings about those behaviors should be considered.

Evaluate the patient based upon the complete DSM-5® diagnostic criteria for B.E.D

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

1. During the last 3 months, did you have any episodes of excessive overeating (i.e. eating significantly more than what most people would eat in a similar period of time)?

Yes No

Note: If you answered "no" to question 1, you may stop, the remaining questions are not applicable.

2. Do you feel distressed about your episodes of excessive overeating?

Yes No

Within the past 3 months…	Never or Rarely	Sometimes	Often	Always
3. During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)?				
4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?				
5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate?				
6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?				
7. During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?				

Generalized Anxiety Disorder -7 (GAD-7)

Instructions: This is a screening measure to help you determine whether you might have an eating disorder that needs professional attention. This screening measure is not designed to make a diagnosis of an eating disorder or take the place of a professional consultation. Please fill out the below form as accurately, honestly and completely as possible. There are no right or wrong answers. All of your responses are confidential.

Exult Healthcare
Phone (469) 714-0006
Fax: (469) 714-0179

Over the last 2 weeks, how often have you been bothered by the following problem?	Not At All	Several Days	Over Half the Days	Nearly Every Day
1. Feeling nervous, anxious, or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it's hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				
Add and Total the Score				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____