Phil Ginsburg, M.A., LPC, LMFT, LCDC, NCC

7825 Highway 6 North, Suite 102, Houston, TX 77095
Tel. (832) 375-1700 Fax (832) 375-1600

Today's Date _____

Patient's Name _____ Marital Status _____ Birth date _____

Address _____ City _____ State ____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

SSN _____ Employer _____ Occupation _____

How Long _____ Employer's Address _____ Employer's Phone _____

If Student, School Name _____ Grade/Grade Completed _____

Allergies _____ Medications _____

Physician _____ Physician Contact Number _____

Spouse's Name _____ # of Children _____ Ages of Children _____

If a client is a minor or student, please complete the following.

Parent's Marital Status _____ Date of Marriage/Separation/Divorce _____

Mother's Name _____ Address _____

Home Phone _____ Work Phone _____ Occupation _____

Employer and Address _____

Father's Name _____ Address _____

Home Phone _____ Work Phone _____ Occupation _____

Employer and Address _____

Whom may we thank for referring you to us? _____

If you are unable to keep appointment, kindly give 24 hours notice or you will be charged for the appointment.

By entering your name in the signature field you agree to use an electronic signature in lieu of a paper-based signature. You understand that electronic signatures, just like your signing a piece of paper, are legal in the United States and in other countries.

I agree that by electronically signing this form that I have read and understand all of the information included on the form.

Signature _____

Phil Ginsburg, M.A., LPC, LMFT, LCDC, NCC
7825 Highway 6 North, Suite 102
Houston, TX 77095

Tel. 832-375-1700 Fax 832-375-1600

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name _____

Date of Birth _____

Social Security Number _____

I hereby acknowledge that I have received and been given an opportunity to review a copy of Phil Ginsburg's, M.A., LPC, LMFT, LCDC, NCC Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact his office.

By entering your name in the signature field you agree to use an electronic signature in lieu of a paper-based signature. You understand that electronic signatures, just like your signing a piece of paper, are legal in the United States and in other countries.

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Signature of Patient/Client _____ Date _____

Signature of Parent, Guardian, or Personal Representative* _____ Date _____

*Please state your relationship to the patient. _____

◯ Patient/Client refuses to acknowledge receipt.

Signature of Staff Member/Witness _____ Date _____

AUTHORIZATION TO BILL CREDIT/ DEBIT CARDS

I, _____ , hereby grant permission to Phil

Ginsburg to charge my credit/ debit card as partial or full payment for

services rendered to _____
(Name of Patient)

_____
(Relation to Cardholder).

Credit Card Type Please Choose One

CREDIT CARD NUMBER: _____

NAME AS IT APPEARS ON CARD: _____

Expiration Date Month Year CRV CODE _____

ZIP CODE ASSOCIATED WITH THIS CARD: _____

Payment Guarantee:

I understand that I am individually responsible for all incurred charges, even if I direct you to bill another person. If I direct charges to be billed to another person, I represent that I am authorized to give you such direction. I understand there is a 24-hour cancellation policy and that I will be charged without providing 24 hours advance notice to cancel a session. If an appointment is scheduled for a Monday, I understand that I must cancel by the preceding Friday prior to 4PM to avoid being charged. It is unlikely that the therapist can fill an appointment for Monday that is canceled over the weekend. In any case if the therapist is able to fill a canceled appointment you will NOT be charged.

I have read, understand and agree to the information, authorization and guarantee stated above.

By entering your name in the signature field you agree to use an electronic signature in lieu of a paper-based signature. You understand that electronic signatures, just like your signing a piece of paper, are legal in the United States and in other countries.

I agree that by electronically signing this form that I have read and understand all of the information included on the form.

Signature _____

_____ _____
Printed Name Date

Phil Ginsburg holds license #11176 as a Licensed Chemical Dependency Counselor, license # 201583 as a Licensed Marriage and Family Therapist and license # 66700 as a Licensed Professional Counselor.

PROFESSIONAL DISCLOSURE STATEMENT

Privacy, confidentiality, and records:

Ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. However, there are exceptions to confidentiality defined in the state and federal statutes. The most common of these **exceptions to confidentiality are when there is a real or potential life or death emergency, when the court issues a subpoena, or when child/elder abuse or neglect is involved.** I also participate in a process where selected cases are discussed with other professional colleagues including supervisors in order to facilitate my continued professional growth and to get you the benefit of a variety of professional experts. While no identifying information is revealed in this peer consultation process, the dynamics of the problems and the people are discussed along with treatment approaches and methods.

If I must discontinue our relationship because of illness, disability, or other presently unforeseen circumstances, I ask you to agree to permit me to transfer your records to another therapist of my choice who will assure the confidentiality, preservation, and appropriate access to your records. By signing this document, you are giving your consent to this request.

Fees, Payments, and Billing:

Payment for services is an important part of any professional relationship. Fees may be paid by cash, debit or credit card. Checks are accepted only by prior arrangement. Currently, unless other arrangements have been discussed, the fee for a session of 45-50 minutes is $150. Payment is made before each session begins so that our time can be used to focus on your primary concerns. Experience has shown that sometimes after a session, a client may be in a thoughtful or emotional place and that they may wish to continue to contemplate what was just discussed rather than suddenly needing to discuss financial arrangements.

I understand there is a 24-hour cancellation policy and that I will be charged without providing 24 hours advance notice to cancel a session. If an appointment is scheduled for a Monday, I understand that I must cancel by the preceding Friday prior to 4PM to avoid being charged. It is unlikely that the therapist can fill an appointment for Monday that is canceled over the weekend. In any case if the therapist is able to fill a canceled appointment you will NOT be charged.

Telephone consultations / appointments:

Of course, there is no charge for brief calls about appointments or similar business. Telephone consultations may be suitable or even needed at times in during therapy, if so, the regular fee will be charged, prorated over the time needed. If you need to have telephone communication that extends beyond 10 minutes, you will be billed for these at the same rate as for regular therapy services.

Availability of services:

My practice does not have the capability to respond immediately to counseling emergencies. True emergencies should be directed to the community emergency services (911). Established clients with an urgent need to contact me can leave a message on my office telephone, and my telephone will notify me that you called, but an immediate response is not guaranteed. A quick or immediate response in one situation does not constitute a commitment of rapid response in another situation.

Purpose, limitations, and risks of treatment:

Counseling therapy, like most endeavors in the helping professions, is not an exact science. While the ultimate purpose of counseling is to reduce your distress through a process of personal change, no guarantees can be made or implied. The process of counseling usually involves working through tough personal issues that can sometimes result in emotional discomfort for the client. Attempting to resolve issues that brought you to counseling in the first place may result in changes that were not originally intended. The counseling therapy process may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships, or virtually any other aspect of your life.

Sometimes a decision that is positive for one family member is viewed quite differently by another family member. Change can sometimes be easy and swift, but other times it can be slow and challenging. In the case of marriage and family therapy, there is the potential for harmonious relationship progress; however interpersonal conflict can increase as we discuss family issues. Sometimes clients choose to divorce even after participating in marital therapy.

Credentials:

I am licensed by the State of Texas as a Licensed Professional Counselor, a Licensed Chemical Dependency Counselor, a Licensed Marriage and Family Therapist. I am also certified by the National Board of Certified Counselors as a National Certified Counselor (NCC). I have earned a Bachelor of Arts Degree in Community Service and Public Policy from the University of Massachusetts-Boston, and a Masters Degree in Counseling from Sam Houston State University. I have clinical experience in treating adults, adolescents, children, couples and families. I reserve the right to refer a client to another therapist or appropriate resource at any time if their needs in therapy are not a good match for my skills or experience.

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Emergency Contacts

Please include the name and phone number of any person you wish for me to contact in case of an emergency or crisis. Should you, the client miss a scheduled appointment without calling, the client grants me, the therapist consent to contact the person(s) listed as an emergency contact for the sole purpose of checking on you, the client's general welfare.

Emergency Contact 1 _____ **Phone #** _____

Emergency Contact 2 _____ **Phone #** _____

I hereby consent to and agree to receive counseling services and acknowledge that I have read the Professional Disclosure Statement of Phil Ginsburg.

By entering your name in the signature field you agree to use an electronic signature in lieu of a paper-based signature. You understand that electronic signatures, just like your signing a piece of paper, are legal in the United States and in other countries.

I agree that by electronically signing this form that I have read and understand all of the information included on the form.

_____ _____

Phil Ginsburg **Client Signature**

Date _____ **Date** _____

Authorization to Release Information

I, _____, hereby authorize Phil Ginsburg, M.A., LPC, LMFT, LCDC, and NCC to release information to, or obtain information from:

(PRINT NAME, PHONE NUMBER AND ADDRESS OF OTHER[S])

regarding: myself as patient, or (PRINT PATIENT'S NAME) _____ , as patient for whom I am parent, legal guardian, or authorized representative.

Patient's date of birth is _____

Information authorized for release is:

Any and all psychological/medical information, billing records, medical records, facts, reports, notes, history, professional opinions, psychotherapeutic treatment or counseling, testing, or records of others relating to the patient's medical, psychological, counseling, alcohol use, drug use, vocational, and educational...background, conditions, and behavior.

I understand that Phil Ginsburg, M.A., LPC, LMFT, LCDC, NCC will use any and all such information received only in my (or patient's) evaluation, assessment, diagnosis, prognosis and treatment. I also understand that Phil Ginsburg, M.A., LPC, LMFT, LCDC, NCC has no control over how "Other(s)" use information released to them.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon. Unless expressly revoked, this authorization becomes effective immediately and shall remain in effect for one year after the signature date below. Revocation shall be in writing with proof of receipt by Phil Ginsburg, M.A., LPC, LMFT, LCDC, NCC.

I have read the above and fully understand its content in its entirety. I further understand that I have a right to receive a copy of this authorization upon my request.

Signature _____ Date _____

Witness _____ Date _____

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Once you are finished filling out this form, please save this file to your hard drive, and then email it as an attachment to Phil Ginsburg at phil@houstonfamilyservices.com or print it out and bring to your appointment.

Save