

# **Jennifer Bilbrey, LPC**

## **Client Information Sheet**

Today's Date: \_\_\_\_\_

Name:

\_\_\_\_\_

DOB:

\_\_\_\_\_

Current Relationship Status:

\_\_\_\_\_

Children: Y N

If yes, how many: \_\_\_\_\_

Address:

\_\_\_\_\_

\_\_\_\_\_

City/St/Zip:

\_\_\_\_\_

Email:

\_\_\_\_\_

Okay to Email? Y/N

Home/Cell #: \_\_\_\_\_

Okay to Call? Y/N Okay to Leave Voicemail? Y/N Okay to Text? Y/N

Work #:

\_\_\_\_\_

Employer:

\_\_\_\_\_

# **Jennifer Bilbrey, LPC**

Occupation:

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How Long?

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**What brings you here today?**

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**Current/Ongoing Medical Conditions:**

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**Current Medications/Supplements:**

Rx/Reason for Taking/Dosage/Date Prescribed

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Please list the names of providers with whom you currently work:

Physician (MD or DO): Y N

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Homeopath/Naturopath: Y N

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Other:

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# **Jennifer Bilbrey, LPC**

## **Previous Counseling and/or Mental Health Hospitalizations:**

Dates/Location/Reason/Outcome – (i.e. Issue Resolved?)

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## **Who Referred You or How Did You Find Me?**

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## **Emergency Contact Information:**

Name:

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Phone:

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Relationship:

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# **Jennifer Bilbrey, LPC**

## **Client Agreement**

Welcome and thank you for making the decision to enter therapy! In this first session, I want to take the time to get to know you and what brought you to therapy. I also want to discuss my approach to us working together. I like to think of therapy as a turning on and a turning inward of a flashlight. In an attempt to safely make it through our often hectic lives, we move throughout our day unaware of reactions, our feelings and ourselves. At the same time, we are often painfully aware of how others respond to us seemingly ineffectively. In essence, our flashlight is pointed outward. Working together, we will begin to shine the flashlight inward, patiently and compassionately wondering what's inside. By doing this, we also begin to take greater responsibility for ourselves, and the way we are in relationship. I am hopeful that with this newfound information will come freedom and wholeness for you and important others in your life. And that is my promise to you – to provide a safe, hopeful and challenging environment in which we both grow as a result. Before we begin treatment, there are a few items we need to address. This information is given to you with the intention of creating a relationship I most want us to have – one with clear expectations of each other and where we are both safeguarded and supported. I look forward to getting to know you and to discovering your own unique path to health.

### **Sessions**

- **Counseling sessions are scheduled for 50 minutes. Therapy sessions may be scheduled for longer as agreed. Usually sessions are scheduled weekly at the same time.** For sessions that occur more or less frequently, please allow for more flexibility in your schedule so that your request may be accommodated.
- If you are late, we will begin late but we will end at the originally scheduled time. Please call if you are going to be more than 15 minutes late to your session. If a pattern of late arrivals and missed appointments appears, I will no longer be able to hold a specific time slot for you and may discontinue service.
- My practice is not setup for crisis care. If you need immediate attention, go to your nearest emergency room, call 911, or call one of the following hotlines: 512-472-HELP, 800-SUICIDE or 800-273-TALK.

### **Cancellations**

- Please inform me of any cancellations at least 24 hours in advance by calling (512) 669-0395 and leaving a voicemail or emailing [jbilbreycounseling@gmail.com](mailto:jbilbreycounseling@gmail.com). **Failure to cancel a session without 24 hours notice will result in a missed session fee per missed appointment. The fee is the same as your session fee.** This fee is subject to change.

# Jennifer Bilbrey, LPC

## Payment

- My fee is typically \$120 for each session, unless you and I have negotiated differently. This fee is subject to change.
- *Some clients prefer to pay for several sessions in advance as I offer a discount. If you pre-pay for 9 sessions, I will include your 10<sup>th</sup> session at no additional charge. (This means you pay for 9 sessions and get 10.) Please note that if you select this option, a refund cannot be issued for any portion of the pre-paid sessions should you choose to terminate before your sessions end. Also note that the cancellation policy (see above) still applies. This means that if we had an appointment scheduled but you cancel without the 24-hour notice I will deduct one session, just as if you had attended.*
- Please note that it is the intention to increase fees on a periodic basis. You will be given advance notice if fees are increased. If a fee increase would present a financial hardship for you, we will discuss alternative treatment options. I will provide you with several referrals for counseling services that fit your budget and will work to facilitate your transfer to another treatment provider.
- **Payment for service is due at the beginning of session.**
- **You may pay by cash, check, or with a credit card by using PayPal through my website, [www.jenniferbilbrey.com](http://www.jenniferbilbrey.com) prior to the session.** No session will be held if no payment is collected and sessions will be suspended if there is an outstanding balance. There is a \$25 charge for all returned checks.

## Confidentiality

- Please read the Notice of Privacy Practices. I want to emphasize that our relationship and the content of our sessions are confidential except in case of the following:
  - Suspicion of abuse or neglect to children, elderly or the disabled
  - Threat of harm to yourself or others
  - Sexual contact with another therapist
  - Court order
  - Collecting payment for services to include credit card processing and insurance utilization
  - You have consented in writing to the release of your confidential information
- It is important to remember that our relationship is professional and never social. If I see you outside of a therapy session, I will protect your confidentiality by not acknowledging you unless you initiate.

# **Jennifer Bilbrey, LPC**

## **Termination**

- Client and therapist ideally mutually agree upon termination of the counseling/therapy relationship. The goal is for clients to be content with their direction in life or toward a solution and relatively confident in their skills and abilities to accomplish such.
- Termination of the counseling relationship will automatically occur if there has been no contact between client and therapist for three (3) weeks without an agreed plan for such break in contact.

## **Contacting Me**

- I make every effort to return phone calls within 24 hours although occasionally there are unavoidable delays. Routine calls received after 5 pm will be returned on the next business day.
- If you need to speak with me immediately, please indicate so on my voicemail and I will make every effort to call you back as soon as I possibly can.
- My practice is not setup for crisis care. If you need immediate attention, go to your nearest emergency room, call 911, or call one of the following hotlines: 512-472-HELP, 800-SUICIDE or 800-273-TALK.

## **Electronic Communication**

- No form of communication outside of session is guaranteed to be private. By using any electronic method to send messages to me, I will assume you have made an informed decision to take the risk that the message may be intercepted. Emails, text messages and phone calls are ideally for arranging or rescheduling appointments.
- I maintain professional pages on social media sites for networking and marketing. I do not recommend you associate yourself publically in any way to my professional pages because these sites are not confidential. Please do not contact me through social media as I will not reply and may delete any communication I deem inappropriate. If you do "like" one of my professional social media sites, like Facebook, I will assume you have made an informed decision about how that choice compromises your confidentiality.

## **Insurance & Managed Care**

- You are responsible for payment of services in full at the time they are rendered.
- If you are considering using insurance for mental health care, please be aware of some of the complications of using a health care benefit, which requires a psychiatric diagnosis and may include loss of control of treatment and a risk to confidentiality, privacy, and ability to obtain health or life insurance in the future. Some diagnostic categories are not payable by some insurance and managed care entities. Your insurance is a relationship between you and the insurance company.

# **Jennifer Bilbrey, LPC**

## **Court Fees**

- I do not recommend using your therapy as a tool for court cases, as it will open up your personal process to dissection and interrogation. If I am ordered to appear, I require payment 72 hours in advance at the rate of \$300 per hour. This includes travel, preparation, consultation, appearances and time on-call. You are responsible for any legal fees I incur related to your case (litigation issues, lack of payment, etc.).

**Please request a copy of this document if needed. Sign and date below to confirm your understanding and agreement:**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Printed Name

# **Jennifer Bilbrey, LPC**

## **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.**

I am required by law to maintain the privacy of your protected health information (PHI). PHI includes any information I obtain that identifies you and relates to your past, present, or future physical or mental health, to the treatment/services I provide to you and/or to the payment for those services. I am required to provide you this notice of privacy practices and am required to abide by the terms of this notice. I reserve the right to change the terms of this notice at any time and you have the right to request the most current copy of my policy.

**I am permitted to use and disclose your health information without your authorization for:**

- 1. Treatment** - activities involved in the provision, coordination, and/or management of your mental health care. This includes an LPC-Intern consulting with a clinical supervisor or an LPC consulting with another health care professional to coordinate care and/or make treatment decisions.
- 2. Payment** - activities related to receiving reimbursement for my services. An example is when I submit requests for authorization and payment to your insurance company.
- 3. Health Care Operations** - activities related to the performance and operation of my practice. An example is when information is necessary for insurance, audits, credentialing or other business related functions. This also includes business associates, like billing companies to submit claims to health insurance companies.
- 4. Legal Requirements**
  - a. **Abuse/Neglect** - I am mandated to report any suspicion of past, current and/or future abuse and or neglect of a minor, a disabled individual or an elderly person to the appropriate public authorities.
  - b. **Threat of Harm** – I have the right to report any serious and imminent threat to you, another person or the public to the appropriate party and/or law enforcement.
  - c. **Court Order**
  - d. **Health Oversight** - activities such as inspections, audits, investigations, and licensure actions necessary for monitoring compliance with civil rights laws, government programs and the general healthcare system. This includes disclosures to the Secretary of the Department of Human Services in relation to my compliance with the privacy rule.

Jennifer Bilbrey, LPC \* License #71324 \* 8500 Shoal Creek Blvd, Ste 114,  
Austin, TX 78757 \* [jbilbrecounseling@gmail.com](mailto:jbilbrecounseling@gmail.com) \* [www.jenniferbilbrey.com](http://www.jenniferbilbrey.com)



# **Jennifer Bilbrey, LPC**

**Your Health Information Rights.** You have the right to:

- Review and obtain a copy of your PHI in your medical record except for psychotherapy notes and information compiled for legal proceedings. I may deny access if I believe access could cause harm to you or another. In such situations, you have the right to have the denial reviewed by a licensed health care professional for a second opinion. I may impose reasonable, cost-based fees for copying and postage. If your records are maintained electronically, you may also request an electronic copy of your PHI.
- Request an amendment to the PHI in your record, when that information is inaccurate or incomplete, by delivering the request in writing to my office. If I deny your request, I must provide you the denial in writing and allow you to submit a statement of disagreement for inclusion in the record. If I accept your request, I must make reasonable efforts to provide the amendment to persons I have identified as needing it and to persons I know might rely on the information to your detriment. I must also amend your record if I have received a notice to amend from another health care provider.
- Obtain an accounting of PHI disclosed during the six years preceding your request for that information. This does not include disclosures for treatment, payment or healthcare operations. This does not include your requests for disclosure. This does not include disclosures I am legally obligated to make.
- Restrict health information use and disclosure although I am under no obligation to agree to those requests. If you pay out-of-pocket for services, you may request that your PHI not be shared with your insurance company.
- I do not release PHI or sell PHI for purposes of marketing or fundraising.
- Request an alternative means or location for receiving communications of PHI by means other than what I typically employ. For example, you may request an alternate phone number or mailing address.
- Obtain a paper copy of the current Notice of Privacy Practices for PHI by making a request at my office.
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to my office. If I deny your request, you may submit an appeal.
- Revoke any authorizations that you made previously to use or disclose information by delivering a written revocation to my office, except to the extent information or action has already been taken.

*Jennifer Bilbrey, LPC \* License #71324 \* 8500 Shoal Creek Blvd, Ste 114,  
Austin, TX 78757 \* [jbilbrecounseling@gmail.com](mailto:jbilbrecounseling@gmail.com) \* [www.jenniferbilbrey.com](http://www.jenniferbilbrey.com)*

# **Jennifer Bilbrey, LPC**

## **To Request Information or File a Complaint**

Please contact me if you have further questions, would like more information or if you have a complaint about the handling of your PHI.

**Jennifer Bilbrey, LPC**  
**8500 Shoal Creek Blvd, Suite 114**  
**Austin TX 78757**  
**Phone 512-669-0395**

You may also file a complaint with the Department of Health and Human Services by visiting their website at <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html> or contacting:

**Office of Civil Rights Region VI**  
**1301 Young Street, Suite 1169**  
**Dallas TX 75202**  
**Phone 214-767-4056, Fax 214-767-0432**

**Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights**  
**200 Independence Ave, S.W. Rm. 509F**  
**Washington, D.C. 20201**

I cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from this office. I also cannot, and will not, retaliate against you for filing a complaint.

**I acknowledge I received a notice of privacy practices.**

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**Client Signature**

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**Date**

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**Client Printed Name**