Sean Berkley, LCSW

601 West 18th Street, Austin, TX 78701 | www.seanberkley.com | 512-300-3062

***Note**: each partner needs to fill out their own Client Information form, which is included here twice (see below).*

Confidential Client Information

Name_____ Date_____

Address_____

_____

Phone _____ Okay to send texts? Y / N Okay to leave voicemails? Y / N

Note: confidential client information will never be communicated by text or voicemail

Email _____

Occupation _____ Employer _____

Date of Birth _____/_____/_____ Gender _____

Ethnic Background _____ Faith _____

Sexual Orientation (circle one) lesbian / gay / straight / bisexual / other: _____

Preferred Name _____ Name of Physician _____

Relationship status _____

How did you hear about me or this practice? _____

If referred, referred by? _____

Name(s) of previous therapist(s) and approx. dates seen _____

_____

Describe any health concerns _____

_____

List drugs/medications you presently use _____

Please describe briefly the concerns that bring you here: _____

_____

_____

_____

Please check any of the following items which concern you:

____ Self-esteem, self-confidence	____ Family conflicts or pressures	____ Friendship issues
____ Anxiety, phobias, fears	____ Low mood, depression	____ Sleep problems
____ Relationship concerns	____ Angry or hostile feelings	____ Sexual concerns
____ Shyness, being assertive	____ Procrastination, motivation	____ Physical distress
____ Traumatic experiences	____ Eating or appetite concerns	____ LGBTQ concerns
____ Suicidal feelings, behaviors	____ Alcohol or drug concerns	____ Stress
____ Work or career concerns	____ Parent-child concerns	____ Health concerns
____ Isolation, loneliness	____ Self-control	____ Panic attacks

Other:_____

_____

_____

Please list the members of your immediate family (parents, siblings, spouse/partner, children)

Name	**Relationship**	**Age**	**Live with?**

Sean Berkley, LCSW

601 West 18th Street, Austin, TX 78701 | www.seanberkley.com | 512-300-3062

***Note**: each partner needs to fill out their own Client Information form, which is included here twice (see below).*

Confidential Client Information

Name_____ Date_____

Address_____

_____

Phone _____ Okay to send texts? Y / N Okay to leave voicemails? Y / N

Note: confidential client information will never be communicated by text or voicemail

Email _____

Occupation _____ Employer _____

Date of Birth _____/_____/_____ Gender _____

Ethnic Background _____ Faith _____

Sexual Orientation (circle one) lesbian / gay / straight / bisexual / other: _____

Preferred Name _____ Name of Physician _____

Relationship status _____

How did you hear about me or this practice? _____

If referred, referred by? _____

Name(s) of previous therapist(s) and approx. dates seen _____

_____

Describe any health concerns _____

_____

List drugs/medications you presently use _____

Please describe briefly the concerns that bring you here: _____

_____

_____

_____

Please check any of the following items which concern you:

____ Self-esteem, self-confidence	____ Family conflicts or pressures	____ Friendship issues
____ Anxiety, phobias, fears	____ Low mood, depression	____ Sleep problems
____ Relationship concerns	____ Angry or hostile feelings	____ Sexual concerns
____ Shyness, being assertive	____ Procrastination, motivation	____ Physical distress
____ Traumatic experiences	____ Eating or appetite concerns	____ LGBTQ concerns
____ Suicidal feelings, behaviors	____ Alcohol or drug concerns	____ Stress
____ Work or career concerns	____ Parent-child concerns	____ Health concerns
____ Isolation, loneliness	____ Self-control	____ Panic attacks

Other:_____

_____

_____

Please list the members of your immediate family (parents, siblings, spouse/partner, children)

Name	**Relationship**	**Age**	**Live with?**

Sean Berkley, LCSW

601 West 18th Street, Austin, TX 78701 | www.seanberkley.com | 512-300-3062

Office Policies & Informed Consent

Thank you for choosing me as your mental health provider. The following are my policies.

FEES: My fee is $120 per 50-minute session. In certain circumstances I charge for professional services (such as phone consultations, meetings, or report-writing) in addition to in-person therapy. Reduced rates are offered based on availability of designated slots.

PAYMENT FOR SERVICE: Payment is due at the time of service. I accept payment by cash, check, credit card, or debit card. I charge a $2 processing fee for credit and debit cards and a $20 fee for returned checks. When requested, I will provide a monthly statement that may be used to obtain reimbursement.

CANCELLATIONS: Clients are responsible for paying for their scheduled time unless they cancel more than 24 hours in advance.

ANSWERING SERVICE: You may leave a message for me at any time, 24/7. I will return your call by the end of the next business day.

EMERGENCIES: In the event of an emergency, please contact me at (512) 300 – 3062. When I am unavailable, and you need to speak with someone immediately, please make use of the emergency services listed below:

24-hour Crisis Hotline: **472-4357**

Seton Shoal Creek Psychiatric Hospital: **324-2000**

General Emergency Number: **911**

CONFIDENTIALITY: To the degree allowed by law, information about your contact with me and my office will not be disclosed to any person or organization unless you give me a specific, written, authorization to do so. In all aspects of my practice, communication between my clients and me (or between me and those whom my clients have authorized me to contact) are protected by confidentiality regulations as stipulated by federal and state laws, and by professional standards and ethics.

Some situations deny me complete control over confidentiality of communication:

1. I am legally required to report any situation of suspected abuse, neglect, or exploitation of a child or vulnerable adult to the proper authorities.

2. In some circumstances, my records may be subject to a subpoena issued by the court. In particular, confidentiality may be waived with regard to any suit affecting the parent-child relationship.

3. If I believe a client may harm her/himself or another individual, I am permitted by law to break confidentiality by contacting law enforcement officials and/or medical authorities who may then take protective actions.

4. If I am contacted by an insurance company or an auditor, I may be required to release client information as dictated by law. The law also permits me to release information to a collection agency in order to collect on an overdue account.

5. If a client discloses to me the identity of a mental health professional who engaged in sexual contact with him or her during the process of treatment, state law requires me to report that professional to the appropriate district attorney. In this situation, I am not permitted to disclose the identity of the client if he or she does not wish to be identified.

6. Confidentiality does not extend to criminal proceedings in Texas.

CONFIDENTIALITY WITH REGARD TO MINORS: The parents or legal guardians of clients under the age of 18 have the right to access their child's psychological records. The exception to this is in the case of an emancipated minor. A minor is emancipated if he or she is on active duty with the armed services, is married, or is 16 years of age or older and resides separate and apart from his/her parents, managing conservator, or guardian and manages his/her own financial affairs. I will discuss with you the limitations, procedures, and implications with regard to your child's records and progress.

GRIEVANCE / COMPLAINT: You have the right to file a confidential grievance if you have an unresolved concern regarding therapy or the therapist. Any grievance should be in written form and addressed to Sean Berkley, LCSW, 601 W. 18th Street, Austin, Texas 78701. You may also contact the Texas State Board of Social Worker Examiners at (512) 834-6677, 1100 West 49th Street, Austin, TX 78756.

Sean Berkley, LCSW
601 West 18th Street, Austin, TX 78701 | www.seanberkley.com | 512-300-3062

Agreement

I hereby grant my permission for any counseling, testing, or diagnostic evaluation that may be deemed necessary by my therapist. I understand that therapy is a joint effort between the clinician and client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances. I agree that I will be responsible for the payment of all professional fees. I know that I can end therapy at any time I wish and that I can refuse any requests or suggestions made by my therapist. I have read, understand, and agree to the Office Policies described above.

_____	_____
Client Name (please print)	Client Name (please print)
_____	_____
Client Signature	Client Signature
_____	_____
Date	Date

Sean Berkley, LCSW
601 West 18th Street, Austin, TX 78701 | www.seanberkley.com | 512-300-3062

Authorization for Credit Card Transaction

I _____ (paying party) authorize **Sean Berkley, LCSW**, to charge the following credit or debit card account for attended appointments and missed appointments not cancelled more than 24 hours in advance.

_____
Name (as it appears on the card)

_____
Card Number

_____
Zip Code (billing address)

_____ _____
Exp. Date V-Code

_____ _____
Paying Party Signature Date

Sean Berkley, LCSW

601 West 18th Street, Austin, TX 78701 | www.seanberkley.com | 512-300-3062

NOTICE OF PRIVACY

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.

My commitment to your privacy. My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private.

How I use and disclose your protected health information with your consent.

I will use the information I collect about you mainly to provide you with treatment, to arrange payment for our services, and for some other business activities that are called, in the law, health care operations. After you have read this notice I will ask you to sign below to authorize me to use your information in these ways. lf you do not consent and sign this form, I cannot treat you. lf I want to use, share, or release your information for other purposes, I will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. I will only share information with persons who are able to help prevent or reduce the threat.
2. When I am required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires me to do so.
4. For workers' compensation and similar benefit programs.

Your rights regarding your health information

1. You can ask me to communicate with you in a particular way or place that is more private for you. For example, you can ask me to call you at home, and not at work, regarding appointments. I will try to do as you ask. You can ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.
2. You have the right to look at the health information I have about you, such as your medical and billing records. (Please note that psychotherapy notes do not fall under this jurisdiction). You can get a copy of your medical and billing records, but I may charge you for it.
3. If you believe that the information in your records is incorrect, or missing something important, you can ask me to make additions to your records to correct the situation. You have to make this request in writing. You must also tell me the reasons you want to make the changes.
4. You have the right to a copy of this notice.
5. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with Sean Berkley, LCSW, and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you. Also, you may have other rights that are granted to you by the laws of our state, and these may differ from the rights described above. I will be happy to discuss these situations with you.

If you have any questions regarding this notice or my health information privacy policies, please contact me, Sean Berkley, LCSW, at (512) 300-3062 or at sib@utexas.edu.

Effective Date:_____ **Signature**:_____

Effective Date:_____ **Signature**:_____