Reclamation Center

The Process of Reclaiming Yourself

OUTPATIENT ADMISSION RECORD

CLIENT _____ SOCIAL SECURITY # _____
Last First Middle

ADDRESS _____
Street, Box and Apt. No. City Texas Zip

SEX _____RACE _____DATE OF BIRTH _____PHONE # _____

EMPLOYED BY _____PHONE # _____

NEAREST RELATIVE # _____

ADDRESS _____
Street, Box and Apt. No. City Texas Zip

SOURCE OF REFERRAL (Please be as specific as possible) _____

GUARANTOR INFORMATION

NAME _____ PHONE # _____
Last First Middle

RELATIONSHIP TO CLIENT _____ SOCIAL SECURITY # _____

ADDRESS _____
Street, Box and Apt. No. City Texas Zip

EMPLOYED BY _____

1. Payment is expected when services are rendered. VISA/MASTERCARD are accepted. Checks can be made payable to RECLAMATION COUNSELING CENTER.
2. Credit will only be extended to those who make arrangements in advance. Bills will be sent out monthly.
3. Those who fail to pay when agreed upon, will have their credit privileges revoked.

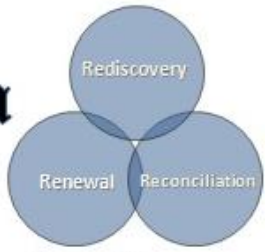
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS FROM SUCH CLAIMS TO BE PAID TO RECLAMATION COUNSELING CENTER.

_____ _____
Signature Date

Diagnostic Impression _____ Case # _____

506 GLASCOW VICTORIA, TEXAS 77904 361-576-3385

Reclamation Center



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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I HEREBY AUTHORIZE _____
TO RELEASE THE FOLLOWING SPECIFIED INFORMATION CONCERNING THIS CLIENT.

FULL NAME OF PATIENT: _____

ADDRESS & TELEPHONE: _____

DATE OF BIRTH: _____

FACILITY TO RECEIVE INFORMATION: _____

THE FOLLOWING INFORMATION IS TO BE RELEASED:

_____INSURANCE CLAIMS
_____DISCHARGE SUMMARY
_____EDUCATIONAL ASSESSMENT
_____SOCIAL HISTORY
_____OTHER, SPECIFY_____
_____

_____ FAMILY HISTORY
_____ INTAKE INFORMATION
_____ TREATMENT PLAN
_____ PROGRESS NOTES

CLIENT SHOULD CHECK/COMPLETE ONE OF THE FOLLOWING:

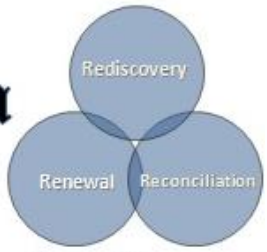
_____INDEFINITELY
_____ONLY FOR A PERIOD OF ONE YEAR FROM THE DATE ON THIS AGREEMENT

FEDERAL REGULATION (42 CFR PART 2) PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS.

DATE_____ WITNESS_____

PATIENT_____ PARENT_____

Reclamation Center



The Process of Reclaiming Yourself

Notice of Privacy Practices

1. **THIS NOTICE DESCRIBES HOW CERTAIN INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.** This notice is provided by Reclamation Counseling Center and briefly summarized how your health information can be handled.

2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of service that you receive. For example, your health information may be shared with another provider to whom you may be referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information.

3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions. If you request copies, we may charge you a cost based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

4. **Our legal duty.** We required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the reception area. You can also request a copy of our notice at anytime.

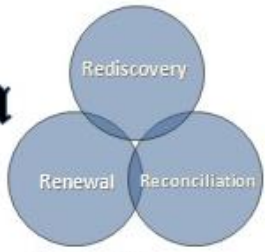
5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact our Privacy Officer at (361) 576-3385. You also may send a written complaint to the U.S. Department of Health and Human Services.

I hereby acknowledge that I have received this Notice of Privacy Practices, dated April 14, 2003.

_____ _____

SIGNATURE DATE

Reclamation Center



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Informed Consent

This is a professional counseling facility.

Professional therapists, licensed by the state, do our counseling. We offer professional counseling to individuals struggling with a variety of issues. Therapy can last from a few weeks to several months. Most people remain in therapy until they feel they have learned better methods of thinking, feeling, and/or acting regarding their difficulties. Most people find therapy very helpful. However, depending on the nature of the difficulty, you might also experience uncomfortable emotions such as anger, fear, and frustration during the course of counseling. While your counselor cannot remove these feelings from you, they will help you work through them or find an alternative counselor. You are free to discontinue therapy at anytime. Occasionally therapists elect to discontinue therapy. This usually happens when they feel no substantial progress is being made or other factors are interfering with their ability to help you. If therapy ends prematurely, we will help you find qualified help elsewhere.

Under normal circumstances everything you discuss with your counselor will be held in strict confidence. However, you should be aware that there are situations in which your counselor may be required by law to report information to the proper authorities without your permission or knowledge. These situations include, but may not limited to a client's indication of bodily harm to others, involvement in a felony, suicidal intentions, and reasonable evidence of child or elder abuse or neglect. Your counselor may also disclose information in response to a subpoena issued by a court of law.

Time is valuable to our therapists and clients. Twenty-four (24) hour advance notice must be given to cancel an appointment. Failure to do will result in a $50.00 charge being affixed to your bill. Only verifiable emergencies are excluded from this fee.

As a courtesy, we will file your insurance claim form. But, in the event that we do not hear from the insurance company within 60 days, you, the client or guardian will be responsible for the full amount of the fee.

"I understand the above issues and agree to receive counseling services from Reclamation Counseling Center."

Client Signature_____ Date_____

506 GLASCOW VICTORIA, TEXAS 77904 361-576-3385

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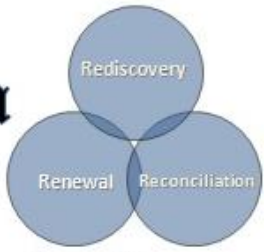

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Client Information

Welcome: Thank you for selecting us. Our goal is to provide you with quality professional care. The following is to inform you of our policies and procedures. We will be happy to answer any of your questions.

Canceling and making appointments: Sessions are conducted by appointment only. You can schedule an appointment by phone during the office hours: 8:00 AM –6:00 PM, Monday through Thursday and 8:00 AM – 2:00 PM on Friday. If you are unable to make your appointment, or are going to be late, please call the office as soon as possible. Unless previous arrangements have been made, you may be charged for missed appointments unless you cancel at least 24 hours in advance of the appointment time.

Emergency situations and after-hour coverage: If you have an emergency, be sure to tell the person answering the phone so prompt action may be taken. They will contact your therapist, or another therapist who is on call. Please make sure that the person answering the phone has your correct name and telephone number.

Fees: The length of the individual, group, family, and marital sessions vary. The staff will be happy to discuss charges for specific services with you. Please do not hesitate to discuss fees with your therapist.

Billing and collection procedures: We prefer you pay at the end of each visit. However, you can elect to receive a monthly statement. We ask that you pay promptly, unless other arrangements have been made in advance. If you ever have any questions about your statement, please call our office. Your health insurance may pay all or part of all your fees. If you wish, we will do the paperwork and file your claims for you. Many of our clients think this is both convenient and helpful in limiting “out of pocket” payment.

Client Signature_____Date_____

506 GLASCOW **VICTORIA, TEXAS 77904** **361-576-3385**