**GINA WATSON, MS, LMFT**

Licensed Marriage and Family Therapist

14133 Memorial Drive, Suite 4

Houston, Texas 77079

713.443.9787

**Rescheduling:** In the event that you need to cancel or reschedule an appointment, please provide me with *at least* 48 hours’ notice so that I can attempt to schedule another patient during that hour. Missed appointments or cancellations received with less notice will be billed at the full session rate.

**DIRECTIONS**: My office is located in the Memorial Realty (COAD building) at 14133 Memorial Drive at the corner of Rancho Bauer Rd, (2 streets west of Kirkwood.) It is a dark, glass building set slightly back off Memorial behind lots of trees between Kolache Factory and John Daugherty Realtors. I am upstairs (it’s a 2-story building) in Suite 4. If you pass the Elementary School to the west *or* Kirkwood to the east, you have gone too far.

**From I10**, exit Kirkwood and drive south to Memorial. Turn right on Memorial and it will be on your left, between Kolache Factory and John Daugherty Realtors.

**From Beltway 8/Sam Houston Pkwy**, exit Memorial/Kimberly and drive west on Memorial until you pass Kirkwood. It will be on your left just past Kolache Factory but before John Daugherty Realtors.

**From Katy, take I10** to the Dairy Ashford exit and turn right towards Memorial Drive. Turn left (east) on Memorial Drive. It will be one office building past John Daugherty Realtors on the right hand side.

**Personal Information (couples should complete individual paperwork)**

**Date of Initial Assessment:**

Client age: \_\_\_\_\_\_\_\_\_ Client name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse age: \_\_\_\_\_\_\_\_ Spouse name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If minor, parent name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Text: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_I consent to receive text communication \_\_\_\_\_\_\_\_\_\_initial

Private e-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_I consent to receive e-mail communication \_\_\_\_\_\_\_\_ initial

\_\_ Married \_\_ Divorced \_\_ Separated \_\_ Single \_\_ In a relationship

Children (ages): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives in your household (names & ages):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment (What do you do for a living): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you seeing a psychiatrist?\_\_Yes\_\_No Have you ever seen a therapist? \_\_Yes \_\_No

Who referred you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relevant Health Information that impacts mood or mental health?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current life stressors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family history of: ­­­\_\_alcoholism \_\_substance abuse \_\_ physical abuse \_\_sexual abuse

\_\_Depression \_\_Anxiety \_\_other mental health disorders \_\_trauma

**CLIENT NO-SHOW/LATE CANCELLATION POLICY**

When you have an appointment, I reserve that time for you and *make it unavailable to any other client*. If you cancel or reschedule an appointment, it is very rare that I am able to fill that slot with another client when less than 3 to 4 days’ notice is given. Because I am a solo practitioner with a small private practice, my cancellation policy is integral to my business.

I understand that you may need to reschedule when there is an **emergency**. However, if you ***must*** cancel or reschedule due to an emergency, please provide me with at least 48 hours’ notice in order to avoid paying for the full session fee.

Appointments are a purchase of “time” and clients who fail to show up for an appointment, cancel or reschedule with insufficient notice will be charged accordingly.

I am tremendously grateful for your understanding regarding this important issue.

X

Signing above indicates I have read and fully understand the late cancellation policy

**THE BELOW NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**.

When you receive psychotherapy in the private practice of Gina Watson, MS, LMFT I will obtain and/or create health information about you. Health information includes any information that relates to (1) your past, present or future physical or mental health or condition: (2) the health care provided to you and (3) the past, present or future payment for your health care.

The following notice tells you about my duty to protect your health information, your privacy rights and how I may use or disclose your health information.

**THERAPIST DUTIES**

The law requires me to protect the privacy of your health information. This means that I will not use or let other people see your health information without your permission except in the ways I tell you in this notice. I will safeguard your health information and keep it private. This protection applies to all health information I have about you, no matter when or where you sought services. When you are in my office, I will not allow any unauthorized person to interview, photograph or record you without your written permission. I will not tell anyone if you sought, are receiving or have ever received services from me unless the law allows me to disclose that information. *If I see you in public outside of my office, I will not approach you or act as if I recognize you.*

I will ask you for your written permission to use or disclose your health information. There are times when I can use or disclose your health information without your permission as explained in this notice. If you give me your permission to use or disclose your health information, you may take it back (revoke it) at any time. If you revoke your permission, I will not be liable for using or disclosing your health information before I knew you revoked your permission. To revoke your permission, send a written statement signed by you to my office address where you gave your permission, providing the date and purpose of the permission and stating that you want to revoke it.

**Limitations to Confidentiality**

1. Texas State Law designates psychotherapists as Mandated Reporters. We are required to report to appropriate authorities any reasonable suspicion of abuse to children or the elderly.
2. Texas Law also requires that legal authorities must be notified if you express serious intent to harm yourself or another person.
3. If a client reveals to the therapist any evidence of professional misconduct (e.g. sexual involvement) perpetrated by a previous clinical provider, the current therapist is required to report this to the state licensing board.
4. If your records are subpoenaed by court order, I may be required by law to release some or all of your records.

**Problem Resolution:**

If you have a concern or problem regarding therapy that you and your therapist are unable to work out, you may wish to contact:

Texas State Board of Examiners of Marriage and Family Therapists

1100 W. 49th Street

Austin Texas 78756

512-834-6657

I have reviewed this document and understand the limits of confidentiality and have been provided with a separate copy of this information.

Client (or parent if client is a minor) Date

Gina Watson, MS, LMFT Date

**ELECTRONIC COMMUNICATION (TEXT, E-MAIL, SKYPE, FACETIME, CREDIT CARD PROCESSING)**

Information sent over computer servers is generally NOT SECURE and I care about your privacy.  
  
As a general rule, I advise that communications which are confidential in nature, or intended to remain private, should not be sent electronically. **This includes e-mail and text**. Consider that receiving e-mails or text messages from a therapist could alert friends, family or co-workers to the fact that you are receiving services from a mental health professional. You should carefully assess any potential risk to your privacy.

Although I treat all communications with the full confidence which the law provides, the fact is that electronic communications are, by their nature, not secure and could potentially be accessed or intercepted by a third-party.  
  
In addition, there is always a possibility that email will not be received because of spam blockers, a worm or virus, system malfunctions, or other cause. It is important that your communication is received and that you know it was received.

I strongly recommend using a private e-mail address rather than a work e-mail address. If your employer has access to your e-mails they may discover that you are a client of my practice.  
  
Be advised that payments are received and processed via PayPal and/or your credit card company. Charges will appear on your statement under GWWATSON and will never contain the words “counseling” or “therapy” in an effort to safeguard your privacy.

I do utilize e-mail and text message to communicate scheduling and appointment reminders but will not communicate confidential or private health information in electronic form.

**I have been informed of the risks to my privacy and consent to electronic communication from Gina Watson, LMFT.**

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Client Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date