

Today's Date:			
CHILD/TEEN INFORMATION			
Child/Teen Name:		Birth date:	Age: Gender:
Street address:		Cell phone:	Home phone:
P.O. box:	City:	State:	ZIP Code:
Current Grade in School	School Name/School District	Teacher Name(s)	
PHYSICIAN INFORMATION			
Regular Physician's Name:	Address:	Phone:	
Medical Specialist's Name:	Address:	Phone:	
Current Medications:			
PARENT/GUARDIAN INFORMATION			
Father's Name:	Birth date:	Address (if different):	Home phone:
E-mail address:			Cell phone:
Occupation:	Employer:	Employer phone:	
Mother's Name:	Birth date:	Address (if different):	Home phone:
E-mail address:			Cell phone:
Occupation:	Employer:	Employer phone:	
HOW DID YOU FIND US?			
<input type="checkbox"/> Ask <input type="checkbox"/> Bing <input type="checkbox"/> Google <input type="checkbox"/> Yahoo <input type="checkbox"/> Yelp! <input type="checkbox"/> Manta <input type="checkbox"/> Dr. <input type="text"/> <input type="checkbox"/> School <input type="text"/>			
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Gateway Business Directory <input type="checkbox"/> www.chadd.org <input type="checkbox"/> www.fellowshipcounseling.com			
<input type="checkbox"/> www.drmontedavenport.com <input type="checkbox"/> www.lifesolutionsdfw.com <input type="checkbox"/> Facebook <input type="checkbox"/> Twitter <input type="checkbox"/> Linked-in			
<input type="checkbox"/> Other: <input type="text"/>			

Check all of the following that are true of this child and provide details requested.

Child is adopted at what age? _____

Child is a foster child at what age? _____

Reason child is adopted or in foster care: _____

Parents are: Married Separated Divorced Single Deceased

If parents are separated, divorced, or deceased, when did this occur? _____

Child lives mainly with: Mother Father Stepmother Stepfather Other _____

Brother(s): Age(s) _____ Sister(s): Age(s) _____

For **biological parents and siblings**, put a \checkmark in the box if that person has had these experiences.

	MOTHER	FATHER	BROTHER	SISTER	OTHERS
Attention problems					
Learning problems					
Kept back in school					
Articulation problems or stuttering					
Problems understanding or using words					
Thyroid problems					
Mental Retardation					
Genetic Disorders					
Behavior problems					
Depression or Mood Disorder					
Anxiety Disorder					
Other Mental Illness (specify below)					
Drinking problem					
Drug abuse					

Describe any health problems parents or siblings have

MEDICAL HISTORY: Check any of the following that are true of this child's medical history.

PREGNANCY

- | | |
|---|---|
| <input type="checkbox"/> Mother gained less than 15 pounds | <input type="checkbox"/> Mother drank beer, wine, or liquor |
| <input type="checkbox"/> Mother took prescribed medications | <input type="checkbox"/> Mother used narcotic drugs |
| <input type="checkbox"/> Mother smoked cigarettes | |

DELIVERY

- | | |
|--|---|
| <input type="checkbox"/> Breech Delivery | <input type="checkbox"/> Delivery before 8 months gestation |
| <input type="checkbox"/> Cesarean Section Delivery | <input type="checkbox"/> Child weighed less than 5 pounds |
| <input type="checkbox"/> Forceps Delivery | <input type="checkbox"/> Child is a twin or multiple |
| <input type="checkbox"/> Induced Delivery | |

NEWBORN HISTORY

- | | |
|---|---|
| <input type="checkbox"/> Stayed in hospital <u>more</u> than 48 hours | <input type="checkbox"/> Had seizures (fits, convulsions) |
| <input type="checkbox"/> Stayed with mother during recovery | <input type="checkbox"/> Required a special monitor at home |
| <input type="checkbox"/> Needed oxygen | <input type="checkbox"/> Born with congenital defects |
| <input type="checkbox"/> Required Intensive Care | <input type="checkbox"/> Other newborn problems |
| <input type="checkbox"/> Was treated for jaundice | |

MEDICAL HISTORY

- | | |
|--|---|
| <input type="checkbox"/> Glasses prescribed | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Other Eye Problems | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Hearing aide needed | <input type="checkbox"/> Urinary Tract Problem |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Poisoning / Overdose |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lead Poisoning |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Slow weight gain | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Excess weight gain | <input type="checkbox"/> Seizures / Spells |
| <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Thyroid Problems | |

INJURIES/HOSPITALIZATIONS

- | | |
|---|--|
| <input type="checkbox"/> Cuts requiring stitches | <input type="checkbox"/> Admitted to ICU |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Pressure equalization tubes |
| <input type="checkbox"/> Almost Drowned | <input type="checkbox"/> Adenoids removed |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Tonsils removed |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Dental surgery |
| <input type="checkbox"/> Other Injuries | <input type="checkbox"/> Other surgery |
| <input type="checkbox"/> Emergency Room Visits | |
| <input type="checkbox"/> Admitted to the Hospital | |

DEVELOPMENTAL HISTORY

Check any concerns you have about your child's development

- Couldn't walk on his/her own until after the age of 18 months.
- Couldn't put several words together until after the age of 2 years.
- Others had problems understanding his/her speech until after the age of 4 years.
- Has had problems understanding or using spoken language.
- Has had problems seeking to share enjoyment or interests with others.
- Others:

SCHOOL HISTORY

Beginning with kindergarten, list the grades and names of schools attended

Which grades did your child repeat? _____

Check any previous help or services your child has received:

- | | |
|--|---|
| <input type="checkbox"/> ECI | <input type="checkbox"/> Response to Intervention (RtI) |
| <input type="checkbox"/> PPCD | <input type="checkbox"/> Special Education |
| <input type="checkbox"/> Speech therapy | <input type="checkbox"/> Dyslexia |
| <input type="checkbox"/> Oral language therapy | <input type="checkbox"/> Section 504 Accommodations |
| <input type="checkbox"/> Occupational therapy | <input type="checkbox"/> Classroom Accommodations |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Testing Accommodations |
| <input type="checkbox"/> Summer School | <input type="checkbox"/> Academic Language Therapy |

Other:

List all previous evaluations your child has had.

List all previous counseling/psychotherapy your child has had.

What are your child/teen's talents? Check all that apply and provide specific examples.		
X		
	Artistic	
	Athletic	
	Communication	
	Design	
	Interpersonal Skills	
	Leadership	
	Mechanical skills	
	Musical	
	Performing Arts	
	Science	
	Technology	
	Writing	
What personal qualities do you consider strengths for your child/teen? Check all and circle your top five.		
X		X
	Ambition	Kindness
	Bravery	Leadership
	Caring, empathy	Love of Learning
	Competitiveness	Loyalty
	Courage	Mercy
	Creativity	Optimism
	Curiosity	Organization
	Dependability	Patience
	Determination	Persistence
	Eagerness	Perspective
	Energetic	Problem solving skills
	Fairness	Protecting others' interests
	Gratitude	Prudence
	Hard-work	Self-control
	Honesty	Sense of humor
	Hope	Sensitivity
	Humility	Social intelligence
	Humor	Spirituality
	Imagination	Vitality (Zest, Enthusiasm)
	Independence	Spontaneity
	Integrity	Working well with others
What else do you want us to know about your child/teen's strengths?		

Rate how often your child has these problems 0 = Rarely 1 = Sometimes 2 = Often	0	1	2
Problems getting started on tasks.			
Trouble organizing tasks or activities at home and/or school.			
Difficulty prioritizing the most important activities to complete.			
Unsure where to start when faced with multiple step tasks.			
Procrastinates and completes tasks at the last minute.			
Trouble "tuning in" on what the teacher, coach, or parent is talking about.			
Responds to only part of multiple-step instructions.			
Asks parent, teacher or coach to repeat instructions.			
Struggles to stay focused on the right thing at the right time.			
Unable to determine what is most important when studying for tests.			
Struggles to shift attention when necessary.			
Inconsistent alertness throughout the day with or without any rhyme or reason.			
Struggles to sustain effort for most difficult multiple step tasks.			
Seems to over-focus on enjoyable activities.			
Struggles to maintain effort for easy, boring, and/or monotonous tasks.			
Unable to adjust speed to meet the needs of a task.			
Seems to do things the hard way.			
Turns in homework late or not at all.			
Fails to complete schoolwork or chores in a reasonable amount of time.			
Arrives late to class, practice, and/or family activities.			
Asks about the amount of time remaining to complete a task or activity.			
Asks about the amount of time remaining when being disciplined.			
Trouble remembering important information while solving multiple step problems.			
Struggles to recall math procedures (carrying, borrowing, fractions, etc.)			
Unable to consistently recall steps for multiple step tasks.			
Inconsistent approach to problem solving.			
Difficulty learning from experience.			
Fails to consistently apply what he has learned in the past to new activities.			
Trouble monitoring how well he is doing when completing multiple step tasks			
Makes careless errors.			

Rate how often your child has these problems 0 = Rarely 1 = Sometimes 2 = Often	0	1	2
Trouble maintaining momentum to complete complex lengthy assignments.			
Unable to regulate actions to fit the situation (runs or yells inappropriately).			
Trouble anticipating consequences of his or her actions.			
Trouble anticipating consequences of others' actions.			
Unable to consistently transition smoothly from one task to another.			
Unable to handle even the smallest frustrations.			
Loses temper easily when faced with difficulty.			
Trouble delaying gratification.			
Gets impatient when asked to wait turn or wait in line.			
Says he/she feels nervous, anxious, or scared.			
Can't do things he/she wants to because of feeling nervous, anxious, or scared.			
Has to do things over and over to prevent bad things from happening.			
Struggles to make friends.			
Struggles to keep friends.			
Inflexibly insists on specific foods or ways of doing things.			
Seems sad most days.			
Seems irritated most days.			
Has severe temper-tantrums three or more times per week.			
Has trouble with falling or staying asleep more often than not.			
Sleeps less than 3-4 hours per night but still has lots of energy.			
Requires much repetition to learn new concepts in all subjects.			
Struggles to apply concepts in science and social studies.			
Trouble finding the right words to say			
Uses the words "thing" and "stuff" a lot.			
Trouble keeping up conversations with peers.			
Uses negative behaviors (hitting) instead of words to solve problems.			
Trouble getting to the point when talking.			
Trouble telling about a recent experience.			
Difficulty understanding jokes.			
Uses incorrect verb tense when speaking (Yesterday, I goed to the store).			
Trouble forming spoken sentences. (Says words in the wrong order).			

Rate how often your child has these problems 0 = Rarely 1 = Sometimes 2 = Often	0	1	2
Talks a lot but provides very little useful information.			
Blurts out answers in class			
Interrupts others			
Talks excessively when it is inappropriate			
Speaks for long stretches with only brief pauses.			
Speaks much louder than socially acceptable			
Fails to modulate voice volume appropriately			
Appears rude or "in your face."			
Trouble identifying misunderstandings of instructions			
Difficulty monitoring comprehension of orally presented information			
Trouble elaborating verbally on his or her ideas			
Problems making clear explanations on request			
Difficulty answering questions concisely using specific vocabulary			
Trouble understanding social cues			
Says words incorrectly mixing up sounds or syllables (pasghetti)			
Struggles to consistently sound out words when reading.			
Makes mispronunciations when reading aloud.			
Can memorize for spelling tests, but cannot remember words one week later.			
Spelling is very difficult to read or "make out" ("thucvn" for vacation).			
Often spells words the way they sound ("vaykayshun" for vacation).			
Slow contextual reading speed			
Inconsistent reading accuracy			
When reading, calls a word that means the same as the word in the passage.			
Adds or omits words when reading.			
Repeats words or phrases when reading.			
Fails to recall details from what he has read.			
Struggles to recognize cause/effect relationships when reading.			
Unable to consistently draw conclusions or predict outcomes when reading.			
Difficulty making inferences from what has been read			
Slow and effortful and/or fast and careless approach to written work			
Untidy, uneven, illegible handwriting			

Rate how often your child has these problems 0 = Rarely 1 = Sometimes 2 = Often	0	1	2
Poor planning and disorganization of written work			
Poor written sentence construction			
Poor story composition (missing story elements, missing reasons or conclusion)			
Handwriting is slow and laborious			
Uses incorrect grammar (verb tense, noun tense) in written work.			
Written sentences do not make sense.			
Unable to consistently use transition words when preparing written work.			
Inconsistent or rare use of modifiers when preparing written work.			
Struggles to organize good ideas into good written narratives.			
Trouble with sequencing for math			
Trouble learning meanings of words used for math.			
Problems learning math facts.			
Trouble understanding the language of math word problems.			
Trouble solving math problems involving time.			
Makes math procedural errors (carrying and borrowing, division, fractions)			
More overt (out-loud) self-talk to guide actions (rather than using inner speech)			
Slow computation speed			
Difficulty retrieving number facts quickly and accurately			
Trouble ignoring irrelevant information in word problems			
Difficulty solving math problems with multiple procedures or steps			

What are you most concerned about for your child?

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What services and solutions are you interested in for your child or teen?

- | | |
|---|--|
| <input type="checkbox"/> ADHD, Anxiety/Mood Evaluation | <input type="checkbox"/> <i>Parenting Success!</i> |
| <input type="checkbox"/> Evaluation of Learning/Development | <input type="checkbox"/> <i>Student Success!</i> |
| <input type="checkbox"/> Individual Counseling | <input type="checkbox"/> Educational Consultation |
| <input type="checkbox"/> Family Counseling | <input type="checkbox"/> Other _____ |

INFORMATION AND CONSENT FOR TREATMENT

Monte W. Davenport, Ph.D. is a Licensed Professional Counselor (LPC) engaged in providing mental health care services to clients. He is co-owner of Monte W. Davenport, Ph.D. and Associates, a Texas Professional Limited Liability Company (PLLC) doing business as Life Solutions of Dallas-Fort Worth. Throughout this document, the word you means you, your child, and/or your teen.

Dr. Davenport has been trained to provide counseling, assessment, and consultation services. His training and experience allow him to assist you, your child, and/or your teen using a combination of mental health and human development principles and techniques, including the use of psychotherapy, to help improve mental, emotional, social, educational, spiritual, or career-related development. As an LPC, Dr. Davenport may assess, evaluate, and treat mental, emotional, or behavioral disorders and distresses that interfere with mental health. He may also implement and evaluate treatment plans using interventions that include counseling, assessment, consulting, and referral.

The success of your sessions with Dr. Davenport depends on the quality of both his and your efforts: Patients who take responsibility for changing their own thoughts and behaviors and actively work on their problems during and after counseling sessions are more likely to achieve their goals and receive more benefit from counseling than those who do not. Ultimately, you are responsible for lifestyle choices/changes that may result from therapy. You understand and agree that you will participate in the planning of your care, treatment or services, and that you may stop such care, treatment or services at any time.

If you have questions that require legal or medical knowledge, you should seek advice from your attorney or primary care physician or ask Dr. Davenport for a referral to a specialist in your area of concern.

Your relationship with Dr. Davenport is a professional and therapeutic relationship. In order to preserve this relationship and abide by the ethical standards of the Texas State Board of Examiners of Professional Counselors (§ 681.32 Texas Administrative Code, Chapter 681), it is imperative that Dr. Davenport and Monte W. Davenport, Ph.D. and Associates, PLLC refrain from any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Gifts, bartering, and trading services are not appropriate and should not be shared between you and Dr. Davenport.

Record Keeping

Dr. Davenport is required to keep records of your counseling sessions for a period of five years after the date of your last session. These records include dates of treatment, case notes, correspondence, progress reports, and billing information.

Confidentiality

Discussions between you and Dr. Davenport are confidential. No information will be released without your written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: abuse or neglect of minors; abuse, neglect, or exploitation of the elderly; abuse of patients in mental health facilities (§681.33 TAC, Ch.681); criminal prosecutions (§611.004 Texas Health & Safety Code, Ch. 611); child custody cases (§ 611.006 Texas Health & Safety Code, Ch. 611); situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose (§ 611.004 Texas Health & Safety Code, Ch. 611); fee disputes between the therapist and the client (§611.006 Texas Health & Safety Code, Ch. 611); or the filing of a complaint with the licensing board (§611.006 Texas Health & Safety Code, Ch. 611).

Except for the specific situations listed above, you must provide signed permission before Dr. Davenport can share information with anyone about any aspect of counseling, assessment, or consultation services he has provided: you will be required to complete a "Release of Information" form in order to specify who should receive information from your file, what information they are allowed to receive, the purpose for which they may use the information, and the period of time during which you are granting the permission.

Communication

By checking-off the items listed below and signing this form, you consent to allow Monte W. Davenport, Ph.D. and Associates, PLLC to communicate with you using these methods:

- | | |
|--|--|
| <input type="checkbox"/> Home Address | <input type="checkbox"/> Father's E-mail Address |
| <input type="checkbox"/> Home Phone | <input type="checkbox"/> Mother's Cell Phone |
| <input type="checkbox"/> Cell Phone | <input type="checkbox"/> Mother's E-mail Address |
| <input type="checkbox"/> Father's Cell Phone | |
| <input type="checkbox"/> Other: _____ | |

By signing this form, you agree to immediately advise Monte W. Davenport, Ph.D. and Associates, PLLC in writing in the event of any changes in this information.

If you have any questions regarding confidentiality, you should bring them to Dr. Davenport's attention before signing this consent form. By signing this consent form, you are giving your consent to Monte W. Davenport, Ph.D. to share confidential information with all persons mandated by law and you are releasing and holding harmless Dr. Davenport and Monte W. Davenport and Associates, PLLC from any liability that may result.

Appointments and Charges

Payment is expected at the time services are rendered. We accept personal checks, cash and major credit cards (Discover, Visa, MasterCard)

Upon payment, Monte W. Davenport, Ph.D. and Associates, PLLC will provide you a receipt which you can submit to your insurance company for reimbursement. Neither Dr. Davenport nor Monte W. Davenport, Ph.D. and Associates, PLLC participate in any insurance or managed care systems. You are solely responsible for any and all interactions with your insurance company. Neither Dr. Davenport nor Monte W. Davenport, Ph.D. and Associates, PLLC submit billing to insurance for reimbursement. By signing this information and consent form, you acknowledge your understanding that you are solely responsible for any and all fees resulting from services provided by Dr. Davenport.

Notice of Cancellation

Notice of cancellation must be received by phone at least 24 hours before your scheduled appointment; otherwise you will be charged \$65.00 for the missed appointment. You are responsible for calling to cancel or reschedule your appointment at least 24 hours before your scheduled appointment.

Legal Proceedings

In the event disclosure of your records or testimony is required by law, payment will be expected from you, regardless of whose attorney subpoenas Dr. Davenport's involvement. Dr. Davenport charges \$500.00 per hour for any and all time spent on legal proceedings.

Consent for Treatment to be Provided a Minor:

By signing below, you acknowledge that you have the legal authority to seek and grant permission for professional services for the following minor child/children, there being no legal decree disallowing your authority to assume such responsibility.

Name _____ Date of Birth _____

By signing this consent form, you agree for your minor child to receive Mental Health assessment, care, treatment or services, and authorize the Dr. Davenport to provide such care, treatment or services, as are considered necessary and advisable. By signing this *Information and Consent* form, you the undersigned acknowledge that you have both read and understand all the terms and information contained herein. You agree that you have asked questions and sought clarification of anything unclear to you.

Signature

Date

Signature

Date

Consent for Treatment to be provided Adults (for family therapy):

By signing this consent form, you authorize the Dr. Davenport to provide such care, treatment or services, as are considered necessary and advisable. By signing this *Information and Consent* form, you the undersigned acknowledge that you have both read and understand all the terms and information contained herein. You agree that you have asked questions and sought clarification of anything unclear to you.

Signature

Date

Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand that as part of my healthcare, Monte W. Davenport, Ph.D. and Associates, a Professional Limited Liability Company (PLLC), originates and maintains health records describing my health history, symptoms, evaluations, test results, diagnosis, treatment plans, and any plans for the future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The *Notice of Privacy Practices* on page 10 of this questionnaire provides specific information and thorough description of how my health information may be used and disclosed. I have been provided a copy of the *Notice of Privacy Practices* and I have been given an opportunity to review the *Notice* prior to signing this document. I understand that a revised *Notice of Privacy Practices* will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare operations and that Monte W. Davenport, Ph.D. and Associates, PLLC, is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Monte W. Davenport, Ph.D. and Associates, PLLC has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing. I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I acknowledge receipt of the *Notice of Privacy Practices* from Monte W. Davenport, Ph.D. and Associates, PLLC.

Signature of Client or Legal Representative

Date

Signature of Client or Legal Representative

Date

I request that changes to the *Notice of Privacy Practices* be sent to me at this address:

NOTICE OF PRIVACY PRACTICES

**This notice describes how health information about you may be used and disclosed.
This notice explains how you can access your information. Please keep this notice for your records.**

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health and medical record, usually serves as:

- A basis for planning your care and treatment
- A means of communication among the many health professionals who contribute to your care
- A legal document describing the care you received
- A means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facilitation, planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Better understand who, what, when, where, and why others may access your health information
- Make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of Monte W. Davenport, Ph.D. and Associates, PLLC, the information, with the exception of raw test data, belongs to you.

You may request restrictions on how your information will be used and disclosed for treatment, payment, and health care operations:

Monte W. Davenport, Ph.D. and Associates, PLLC must permit and accommodate reasonable requests for you to receive communications by alternative means or at an alternative location.

You have a right to inspect and obtain a copy of your health record with very limited exceptions (as provided for in 45 CFR 164.524) by submitting a written request to Monte W. Davenport, Ph.D. and Associates, PLLC. Access or denial will be provided within 30 days.

You may also request to have the information amended (as provided in 45 CFR 164.528). Monte W. Davenport, Ph.D. and Associates, PLLC may deny the request if the information is complete and accurate or was created by another entity.

Upon request Monte W. Davenport, Ph.D. and Associates, PLLC must provide you a written accounting of all non-routine disclosures made without your consent for up to six years. The first list you request within a 12-month period will be provided at no charge. For documents requested after 12 months, you may be charged.

You may revoke your authorization to Monte W. Davenport, Ph.D. and Associates, PLLC to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Monte W. Davenport, Ph.D. and Associates, PLLC is required to:

- Maintain the privacy of your health information
- Provide you with a written notice of the uses and disclosures of protected health information (PHI) and your rights and Monte W. Davenport, Ph.D. and Associates, PLLC's legal duties related to PHI
- Insure that the notice is provided on the first date of service delivery and posted at the site
- Maintain copies of notices and comply with requirements relating to revisions
- Except in emergencies, Monte W. Davenport, Ph.D. and Associates, PLLC must obtain written acknowledgement of receipt or document good faith effort and the reason acknowledgement was not obtained
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied to us. We will not disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact Monte W. Davenport, Ph.D. and Associates, PLLC at 817-798-3818. If you believe that your privacy rights have been violated, you can file a written complaint to the Texas State Board of Examiners of Professional Counselors at 1100 West 49th Street, Austin, Texas 78756-3183 or call the LPC Board office at 1-800-942-5540.

Disclosures for Treatment, Payment, and Health Operations

We will use or disclose your health information for payment. For example, a bill may be mailed to you. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use or disclose your health information when required or otherwise permitted by law in so far as the use or disclosure complies with and is limited to the relevant requirements of such law. For example, Monte W. Davenport, Ph.D. and Associates, PLLC is required to report child abuse and neglect to the authorities.

Other Permitted or Required Uses and Disclosures Communication

with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information related to that person's involvement in your care.

Marketing: We may contact you to provide information about meetings, treatment activities or other health-related benefits and services that may be of interest to you. Any written marketing communication must be sent in an envelope showing only the address of the sender and recipient must include Monte W. Davenport, Ph.D. and Associates, PLLC's phone number. If you choose not to receive further communications, Monte W. Davenport, Ph.D. and Associates, PLLC must remove your name from the distribution list within five days.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law Enforcement: We may disclose your health information under a special court order meeting the specific requirements of 42 CFR.

Reporting a Crime: **No authorization is required to report a crime (or threat of crime) on the premises or against staff or independent contractors at Monte W. Davenport, Ph.D. and Associates, PLLC. Information provided is limited to circumstances, name and address, and last known whereabouts.**

Public Health: **Information may be disclosed to report cause of death as required by law; report child abuse and neglect as required by law; and to medical personnel who assert reason to believe the health of an individual may be threatened.**

Regulatory Activities: Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more clients, workers, or the public.