

**L. Gordon Brewer, Jr. M.Ed., LMFT  
Individual, Marriage and Family Therapist**

**CLIENT INFORMATION**

Date \_\_\_\_\_

Full Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Preferred Name \_\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Married  Single  Widowed  Divorced  Separated

Spouse (Partner) \_\_\_\_\_ Age \_\_\_\_\_

Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Education: Elementary/ Jr. High School  High School Graduate  Some College  College Graduate  Post Graduate

Children (give ages) \_\_\_\_\_

Medical Conditions \_\_\_\_\_

Medications \_\_\_\_\_

Physician \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_

Have you ever had counseling or therapy before? Yes  No  If yes, please give dates and with whom \_\_\_\_\_

May we contact former counselor/ therapist? Yes  No

Are you currently under psychiatric care? Yes  No  If yes, Psychiatrist Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Are you currently taking any psychotropic medications? Yes  No  If yes, please list \_\_\_\_\_

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

What problems are you having that caused you seek counseling/therapy or be referred? \_\_\_\_\_

Have you ever attempted suicide or had serious suicidal thoughts? Yes  No  If yes, are you having suicidal thoughts now? Yes  No

Have you ever been hospitalized for a mental condition? Yes  No  If yes, when did this occur and where? \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

To the best of my knowledge, the information given above is true and correct.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**L. Gordon Brewer, Jr., M.Ed., LMFT  
Individual, Marriage and Family Therapy**

**Statement of Informed Consent**

I (Client(s)( name) \_\_\_\_\_ agree and give consent for psychotherapy and treatment by L. Gordon Brewer, Jr., M.Ed., LMFT (Therapist). I understand that there are certain risks involved, such as being willing to disclose personal information and be open and honest with the therapist. I understand that I have entered into this therapeutic relationship voluntarily and may terminate treatment at any time, however there might be risks involved in terminating treatment early. The scope and nature of this treatment has been explained to me and I understand that there are no guarantees for treatment outcomes. I understand that the therapy being provided is in conjunction with St. Paul's Episcopal Church Counseling Ministry. I agree to hold harmless and indemnify the therapist and St. Paul's Episcopal Church, its clergy and staff from any damages, suits, claims, or liabilities arising from this therapeutic relationship.

**Confidentiality**

I understand that confidentiality will be maintained at all times within legal requirements of the State of Tennessee and ethical guidelines according to the American Association of Marital and Family Therapists Code of Ethics. I understand that confidentiality will not be maintained if I threaten or give reason to believe that I will harm myself or others. If client(s) are involved in couples or family therapy, it is encouraged that each participant maintains a "no secrets" policy and that issues be addressed openly and honestly during the sessions.

**Privacy of Information (HIPAA)**

I acknowledge that I have been given a copy of the therapists *Health Insurance Portability and Accountability Act (HIPAA) Patient Notification of Privacy Rights* which describes how records and information about my treatment will be handled.

**Credentials and Supervision**

The Therapist is Licensed by the State of Tennessee as Marital and Family Therapist. I understand that the therapist will, on occasion, participate in clinical supervision with other counseling professionals. Cases will be discussed with other counseling professionals solely for the purpose of gaining additional perspective, input and treatment direction. Confidentiality will be maintained in this supervision and the names of clients will not be used. The credentials of the therapist have been explained to me.

**Fees**

I understand the fees involved in this treatment and that payment is expected at the time of the session(s), unless other arrangements have been made. I also understand that failure to pay the expected fee could terminate treatment and the settlement of any unpaid fees will be turned over to a collection agency.

**Appointments**

The length of sessions are 50 minutes. I understand that appointments should be kept and that I should arrive on time for scheduled appointments. If the client is late for the session, the session time will be cut short based on the allotted time for the session. *If the client is more than 15 minutes late for a scheduled appointment, the appointment will be considered as "no show" and will need to be rescheduled. "No shows" for appointments are subject to being charged for the session.* Cancellations need to be made 24 hours prior to scheduled appointments, except in the case of family emergencies.

I have read, understand and agree to the Statement of Informed Consent:

Client \_\_\_\_\_ Date \_\_\_\_\_

Client \_\_\_\_\_ Date \_\_\_\_\_

Therapist \_\_\_\_\_ Date \_\_\_\_\_

### Fee Payment Agreement and Medical Billing Release

I understand the fees involved in this treatment and that payment is expected at the time of the session(s), unless other arrangements have been made. I also understand that failure to pay the expected fee could terminate treatment. "No shows" for appointments will be charged for the session. Cancellations need to be made 24 hours prior to scheduled appointments. The basic session fee is \$85.00 for a 50 minute session.

We offer several payment options for therapy and counseling sessions. Payment for services is expected at the time of the session unless other arrangements with the therapist (e.g. insurance or third party payments). Session payments are due at the time of the session. We are able to accept Cash, Checks, Money Orders as well as Visa, Mastercard, Discover Card and American Express.

#### Payments

Check or Money Orders to: L. Gordon Brewer, Jr., M.Ed., LMFT, 5337 Heritage Ln., Kingsport, TN 37664.

Credit cards are accepted but must be done online using PayPal. Payment by using credit cards will need to be done prior to the session at the website: [www.lgordonbrewer-therapy.com](http://www.lgordonbrewer-therapy.com).

#### Insurance

Coverage for therapy varies according to a person's plan and the insurance company. We will gladly file insurance claims with the understanding that if the insurance plan does not cover therapy, the client would need to use other payment options. Any co-payments are due at the time of the session.

In cases where the client has limited income and does not have health insurance or an EAP available, fees will be charged on a sliding scale based on family income. If this is the case, a copy of the sliding scale schedule will be provided.

*Please check the payment option you plan to use:*

- Check or Cash payment at time of session
- Credit card payment (must be done online through the website)
- Insurance or EAP (please bring copy of insurance card/ info to session)

Insurance Company \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Co-pay \_\_\_\_\_ Primary Insured \_\_\_\_\_  
Employer of Primary Insured \_\_\_\_\_  
Insurance Company Phone \_\_\_\_\_

\*By signing below, I acknowledge I have read, agree to and understand the fee payment policy above. I also authorize the therapist to release necessary medical information to third parties for billing purposes and payment of medical benefits to the therapist (L. Gordon Brewer, Jr, M.Ed., LMFT NPI#1467508820). (\*Lines 12 and 13 on universal insurance claim form CMS-1500)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Client Name(Print) \_\_\_\_\_  
Therapist Signature \_\_\_\_\_

**Health Insurance Portability and Accountability Act (HIPAA)  
Patient Notification of Privacy Rights**

**THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.**

**Preamble**

The Licensing Laws of the State of Tennessee provide privileged communication protections for conversations between your therapist and you in the context of your established professional relationship with your therapist. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "designated medical record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers, and in some cases, not to the patient himself/herself. HIPAA provides privacy protections regarding your personal health information, which is called "protected health information," which could personally identify you. PHI consists of three (3) components: *treatment, payment, and health care operations.*

*Treatment* refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

*Payment* is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided to you.

*Health care operations* are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "medically necessary."

The *use* of your protected health information refers to activities my office conducts in filing your claims, scheduling appointments, keeping records and other tasks *within* my office related to your care. *Disclosures* refers to activities you authorize which occur *outside* my office, such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

**Uses and Disclosures of Protected Health Information (PHI) Requiring Authorization**

The State of Tennessee requires authorization and consent for treatment, payment and health care operations. HIPAA does nothing to change this requirement by law in Tennessee. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you). Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon request. The requirement that you sign an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that I speak with your physician about your treatment and/or medications. Before I talk to that physician, you will first have signed the proper authorization for me to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between therapist-patient in treatment settings, HIPAA permits keeping 'psychotherapy notes' separate from the overall 'designated medical record.' 'Psychotherapy notes' cannot be secured by insurance companies, nor can they insist upon their release for payment of services. "Psychotherapy notes" are *my* notes and are defined as follows: "notes recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and that are separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you; hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time I will be able to limit reviews of your PHI to only your "designated record set" which includes the following: all identifying paperwork you completed at your initial visit, all billing and reimbursement information, a summary of our first appointment, your mental status and progress notes for each session, your treatment plan, discharge summary, reviews by managed care companies, results of psychological testing, and any authorizations you have signed. Please note that the actual test questions or raw data of psychological tests are *not* part of your 'designated mental health record set.

You may, in writing, revoke all authorizations to disclose PHI at any time. You cannot revoke an authorization to disclose PHI that has already been disclosed, or an authorization that was obtained as a condition for obtaining insurance in cases where Tennessee law

provides the insurer the right to contest the claim under the policy.

### **Business Associates Disclosures**

HIPAA requires that I train and monitor the conduct of those performing ancillary administrative services for my practice and refers to these people as "Business Associates." These include our secretaries, telephone answering service, health insurance billing service and collection agency. These business associates need to receive some of your PHI in order to do their jobs properly. To protect your privacy they have agreed in their contract with us to safeguard your information in accordance with state and federal standards.

### **Uses and Disclosures Not Requiring Consent nor Authorizations**

*By law, PHI may be released without your consent or authorization in the following instances:*

1. Child abuse
2. Suspected sexual abuse of a child
3. Adult and domestic Abuse
4. Health oversight activities (i.e. licensing boards investigations)
5. Judicial or administrative proceedings (i.e., court ordered treatment and/or evaluations)
6. Serious threat to health or safety (i.e., Duty to Warn law, national security threats)
7. Workers Compensation claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

***No information will ever be released for any sort of marketing purposes.***

### **Patient's Rights and My Duties**

*You have a right to the following:*

*The right to request restrictions* on certain uses and disclosures of your PHI. I may or may not agree to these restrictions, but if I do, they shall apply unless our agreement is changed in writing. *The right to receive confidential communications by alternative means and at alternative locations.* For example, you may not want your bills sent to your home address so I will send them to another location of your choosing. *The right to inspect and receive a copy* of your PHI in the designated mental health record set for as long as PHI is maintained in the record. *The right to amend* material in your PHI, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care.

### **The right to an accounting of non-authorized disclosures of your PHI.**

*The right to a paper copy* of notices/information from me, even if you have previously requested electronic transmission of same. *The right to revoke any authorization* of your PHI except to the extent that action has already been taken. For more information on how to exercise each of the rights, please do not hesitate to ask me for further assistance. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed. Current practices are applicable unless you receive a revision of my policies at a future time. My duties as a therapist include maintaining the privacy of your PHI, providing you with this notice of your rights and my privacy practices with respect to your PHI, and abiding by the terms of this notice unless it is changed and you are so notified.

### **Complaints**

I am the appointed "Privacy Officer" for my practice per HIPAA regulations. If you have any concerns that your privacy rights have been compromised, please let me know immediately. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

**Effective Date** - May 15, 2007

**L. Gordon Brewer, Jr. M.Ed., LMFT**  
**161 E. Ravine Rd.**  
**Kingsport, TN 37660**  
**Phone: 423-571-7423**  
**Email: lgordonbrewer@gmail.com**  
**Website: www.lgordonbrewer-therapy.com**

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Individual, Marriage and Family Therapist

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### Counseling with Minors Policy

It is the policy of this therapist and St. Paul's Episcopal Church Counseling Center, that when counseling with minors (clients under the age of 18), that **the parent or guardian must remain in the building during the counseling/therapy session.** This policy is in accordance with the Episcopal Diocese of East Tennessee's "Safeguarding God's Children" policy. If the parent or guardian is unable to stay in the building for the session, the session will need to be rescheduled at a time when the parent or guardian can remain in the building.

Confidentiality is a very important part of therapy. However, a child or youth's safety is just as important. If for any reason you feel uncomfortable with your child or youth meeting alone with the therapist, please make this known to the therapist so that other arrangements or referral to another therapist can be made. If you suspect abuse by the therapist, please report this immediately to Children's Protective Services and/or the rector of St. Paul's Episcopal Church.

I have read and agree to the Counseling with Minors policy:

Child/Youth: \_\_\_\_\_ Age \_\_\_\_\_

Parent/ Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Relationship: \_\_\_\_\_

Therapist Signature \_\_\_\_\_

*(A copy of the "Safeguarding God's Children" policy can be found on the internet at:  
<http://www.etdiocese.net/policy/PoliciesProtectChildlren.pdf> . If you do not have access to the internet and would like a copy of the policy, please feel free to ask the therapist.)*

## Directions to St. Paul's Episcopal Church (161 E. Ravine Rd.):

St. Paul's church is located on the corner of Watauga and Ravine Rd. in Kingsport, close to Holston Valley Medical Center. ***The office building is the gray house located on the Watauga Street side of the Church. Walk around the front the Church to the covered walkway to get to the office building.***

From Church Circle: Turn onto Watauga Street; go to the next circle with the large sculpture; St. Paul's Church is located on the left at the circle on the corner of Watauga and Ravine. Park in the parking lot and walk around the front of the church through the covered walkway to the office building (gray house facing Watauga Street).

From Stone Drive: Turn south onto Gibson Mill Rd and stay on Gibson Mill to the circle with the large sculpture; St. Paul's Church is located on the right at the circle on the corner of Watauga and Ravine. Park in the parking lot and walk around the front of the church through the covered walkway to the office building (gray house facing Watauga Street).

**(When you arrive at the office building; please ring the bell or knock and the secretary will "buzz" you in.)**

