Informed Consent

Client-Counselor Service Agreement

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your counselor, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Professional Qualifications

I am a Licensed Professional Counselor (LPC) with the state of Texas, and a member of the American Counseling Association (ACA). I received my Bachelor's degree in Psychology from Simpson University and received my Master's Degree in Psychology from Grand Canyon University.

For licensure and complaint information, you may call 512-837-6658 or write to Texas State Board of Examiners of Professional Counselors, 1100 W 49th Street, Austin, TX 78756-3183.

Minor clients

If you are the parent or guardian and are requesting services for your child/adolescent under the age of 18, I will need your permission to provide counseling services to him/her. Keep in mind while you have the right to question and understand the nature of your child/adolescent's sessions, treatment is usually more effective if your child/adolescent has some privacy. It is therapeutically important that your child/adolescent develops a level of trust with me so if you agree, I will only provide you with a general overview of each session along with your child's level of participation and progress. However, there are limits to confidentiality (listed under "Confidentiality").

Ethical Standards

While the nature of the counseling process is psychologically and emotionally very personal, our relationship as counselor and client is a professional relationship and is maintained within the boundaries of professional ethical principles.

Counseling

Counseling is a place to identify and build on current strengths, learn problem-solving strategies, develop or enhance coping skills, learn more effective ways to communicate with others and receive support and feedback. The counseling relationship is designed to be one that will facilitate change and growth. My belief is that the counselor and the client both have active roles. My goal is to provide a comfortable and supportive environment conducive to insight, healing and personal growth. Your role will be to identify goals that you would like to achieve during the course of counseling and be willing to examine any potential obstacles and strengths that will either hinder or help you move toward obtaining your desired goals.

During the first session (intake session), I will gather information about your history, current strengths, struggles/areas of concern and your goals for treatment. This will be a time for you to ask any questions that you may have and to determine if you wish to proceed with ongoing therapy. I strongly believe that individuals should feel comfortable with the counselor which they choose and, hopeful about counseling. In the next several sessions you will have the opportunity to share your thoughts, feelings and perceptions and request assistance with certain situations/issues that arise between sessions as we also collaboratively work toward achieving the agreed upon treatment goals established during the intake session. An important part of counseling will be to practice new skills and monitor certain behaviors/thoughts. There may be times you are asked to do some "homework" in between sessions that may consist of reading and completing handouts, keeping records or practicing a specific skill. The length and frequency of our counseling together will be determined by your specific needs and goals. We will periodically evaluate your satisfaction and progress. If at any time you have questions or concerns regarding fees, services, or the direction of our sessions, please do not hesitate to address them with me. I welcome any questions and feedback. In the later stage of counseling, we will meet less frequently in preparation for termination. Although you may terminate counseling whenever you wish, it is very helpful to have at least one session together to summarize your progress, and define the work that remains.

Counseling can have benefits and risks and it is important to consider both when making any treatment decisions. Since counseling involves discussing unpleasant aspects of your life, there is a risk that you may experience temporary uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. Counseling has also been shown to have many benefits including improved relationships, a significant reduction in feelings of distress and resolutions of specific problems. I am unable to make any guarantees about how the counseling process will be for you, specifically.

Goals of Counseling

There can be many goals for the counseling relationship. Some of these will be long term goals such as improving the quality of your life, learning to live with mindfulness and self-actualization. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, changing behavior or decreasing/ending drug use. Whatever the goals for counseling, they will be set by you according to what you want to work on in counseling. I may make suggestions on how to reach that goal but you decide where you want to go.

Risks/Benefits of Counseling

Counseling is an intensely personal process which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

However, there are many benefits to counseling. Counseling can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages. Counseling often involves the experience of intense feelings which may include sadness, anger, fear, guilt, or anxiety. It is important to remember that these feelings may be a natural and normal part of the counseling process. It is also important to understand that your family and friends may notice the changes you may choose to make in your life and have varied reactions (including negative and/or oppositional reactions) to these changes.

Appointments

Appointments will ordinarily be 45-50 minutes in duration (a clinical hour), once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you contact us by 1 pm the day before your appointment. If you miss a session without canceling, or cancel after 1 pm the day before your appointment, you will be required to pay for the no show fee. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible the cancelation fee. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

*** You are financially responsible for the session missed unless you have given the proper notice.

***No show or No call is a fee of $50.00

Confidentiality

I will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form before such information will be released. There are some limitations to confidentiality to which you need to be aware. I may consult with a supervisor or other professional counselor in order to give you the best service. In the event that I consults with another counselor, no identifying information such as your name would be released. Counselors are required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or the elderly. If I receive a court order or subpoena, I may be required to release some information. In such a case, I will consult with other professionals and limit the release to only what is necessary by law.

Confidentiality and Group Therapy

The nature of group counseling makes it difficult to maintain confidentiality. If you choose to participate in group therapy, be aware that I cannot guarantee that other group members will maintain your confidentiality. However, I will make every effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in group confidential. I also have the right to remove any group member from the group should I discover that a group member has violated the confidentiality rule.

Confidentiality and Technology

Some clients may choose to use technology in their counseling sessions. This includes but is not limited to online counseling via Skype, telephone, email, text or chat. Due to the nature of online counseling, there is always the possibility that unauthorized persons may attempt to discover your personal information. I will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur. Please be advised to take precautions with regard to authorized and unauthorized access to any technology used in counseling sessions. Be aware of any friends, family members, significant others or co-workers who may have access to your

computer, phone or other technology used in your counseling sessions. Should a client have concerns about the safety of their email, I can arrange to encrypt email communication with you.

Limits of Confidentiality

Clients are assured that confidentiality is protected by ethical practices and the laws of the State of Texas with the following exceptions:

- Any incidence of neglect or abuse of a child, the elderly, or handicapped
- If we determine that the client is a danger to self and/or others
- If we are am ordered by a court to disclose information
- If you request that we disclose information to another party
- We are also required by our licensing board to report any unethical behavior revealed to us about any other helping professional.

If you choose to file insurance or work with a managed care company, information regarding your treatment, diagnosis, prognosis, and the specific issue for which you have come to treatment are available to the insurance or managed care company. I make every effort to release only the minimum information necessary for the purpose requested. Once this information is given to the insurance or managed care company, however, I have no control over how the information is used. You will be asked to sign a release of information if records are requested from our office. You have the right to deny the release of information.

Record Keeping

I may keep records of your counseling sessions and a treatment plan which includes goals for your counseling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. If you would like to have your records released, you will be required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be kept for longer. Records will be kept either electronically on a USB flash drive or in a paper file and stored in a locked cabinet in the counselor's office. Records may also be kept in an EMR (Electronic Medical Record) on a secure server.

Video Surveillance

Our offices are under 24 hour 7 day a week video surveillance for the purpose of security and safety. There is no audio contained on the surveillance. These video files are stored on a secure server.

Fees/Payment

Psychiatric diagnostic evaluation (Intake) – $100
Counseling 45 minutes – $75
Counseling 60 minutes – $100
Online Counseling 45 minutes - $50
Family counseling without the client present – $100
Group counseling 90 to 120 minutes - $60

I will provide a superbill, you can provide to your insurance company as a courtesy to you. Depending upon your coverage your insurance may reimburse you for claims made.

Agreed upon payment is due at the time of service. You may file a claim with your insurance company for the services; however, you are ultimately responsible for the full payment of the fees.

Accepted forms of payment include cash, Credit Card and Paypal.

In addition to weekly appointments, we charge $150 hourly for other professional services you may need, although we will break down the hourly cost if we work for periods of less than one hour. For a copy of clinical records, there is an administrative fee of $25.00 for the first twenty pages and 50¢ for each page thereafter along with a reasonable fee for the cost of mailing, shipping, or delivery.

Other professional services include

- Report or letter writing to teachers, physicians, psychiatrists, etc.
- site visits
- travel time
- longer sessions
- telephone calls lasting longer than 10 minutes
- attendance at meetings or phone consultations with other professionals (that you have authorized)
- preparation of records or treatment summaries

None of these services are covered by your insurance plan. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of our professional time, including preparation and transportation costs. Due to the complexity and difficulty of legal involvement, the fee is $170 per hour.

Insurance

I do not bill insurance companies. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information which will become part of the insurance company files. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to file a claim with insurance.

I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

Cancellation Policy

If you need to reschedule or cancel an appointment, please contact me as soon as possible. Not doing so takes away the opportunity to give that appointment to another client. Your insurance company will not pay for missed appointments. I understand that emergencies happen and will be happy to work with you in those situations.

Appointments cancelled/rescheduled by 1 pm the day prior to the session time will not be charged.

Appointments cancelled/rescheduled not before 1 pm the day prior will be charged $50.

No shows will be charged $50.

Reminder texts/calls are only made when my time allows me to do so. Do NOT rely on this courtesy to keep from missing appointments

One no show may be allowed; after the second occurrence, I may choose to refuse the scheduling of future appointments.
Frequent cancelling/rescheduling will incur a charge and may also result in a refusal of future appointments.

Contact Information

The primary way to get in touch with me is by contacting my direct phone at (430) 201-4646. I do not answer phone calls during session so please leave a detailed message including reason for the call and the best number to reach you (daytime number and evening number). Voicemail messages are confidential and we will return calls as soon as possible or within 24 hours. If you are in crisis and need immediate assistance, please call 911 or go to your nearest emergency room.

Email

I will request your email address. You have the right to refuse to divulge your email address. I may use email addresses to periodically check in with clients who have ended therapy suddenly. I may also use email addresses to send newsletters with valuable therapeutic information such as tips for depression or relaxation techniques. If you would like to receive any correspondence through email, please write your email address here _____.

If you would like to opt out of email correspondence, **please initial here _____** .

Clients' Rights

At any time you may question and/or refuse counseling procedures or methods. You have the right to whatever information you wish to know about the process and progress of counseling.

Consent to Counseling

I have read and fully understand this document. All questions that I had, have been answered to my satisfaction and I recognize that I have the opportunity now and in the future to discuss any question I may have with my counselor. I agree to the policies, procedures and fees explained herein. I agree to accept counseling from you and am voluntarily signing this form.

Client Signature: _____ Date: _____

If the client is a minor list the name of the minor child

Name of child _____

I declare that I am the legal guardian and/or managing conservator of the above-named child and grant permission for his/her psychological treatment.

Print Name: _____

Signature: _____ Date: _____

Consent for Release of Information

Client Information	Name _____ Date of Birth _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____
Clinic/Health Care Provider Who has the information to be released?	Name _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____ Fax Number _____
Receiving Party Who will the information be released to?	Name _____ Relationship to Client_____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____ Fax Number _____
Information to Be Released What will be released?	□Whether the client is in treatment or not □Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case) □Nature of the project (Services offered, purpose and philosophy of program) □Brief statement regarding progress (client's denial, client's understanding of their condition and the disease concept, progress or lack of progress on goals, cooperation with treatment plan and rules) □Brief statement regarding relapse and frequency of relapse (cannot identify specific drugs)
Purpose of Release Why is information being released?	□Referral to other services □Coordination of care □Consultation with Doctor □Consultation with other mental health provider □Transfer of care □Other _____

Signature of Client _____ Date_____

Signature of Provider _____ Date_____

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____. This authorization may be canceled in writing at any time. A photocopy/fax of this authorization will be treated in the same way as an original. Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

I understand that I may refuse to sign this authorization and that refusal to sign will not affect treatment.

I understand that if I have any questions about my clinical records, or the content within, I can contact Thrive Counseling and someone will meet with me to discuss my records.

I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 ('HIPAA'), 45 CFR, Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time and that that any notice to revoke consent must be in writing.

OFFICE POLICY FOR NO SHOW/LATE CANCEL AND OUTSTANDING BALANCE DUE.

We are very committed to serving our clients and strive to accommodate all our clients by making appointments available as soon as possible.

When an appointment is reserved for you, we require that the appointment be cancelled by 1:00 pm the day prior to your appointment if you need to cancel your appointment. We understand that emergencies happen, and we will be happy to work with you in those situations.

If you have any questions, please feel free to speak with us.

****

I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR A MISSED

APPOINTMENT FEE OF *$50.00* AND THAT, IF I CHOOSE TO FILL OUT THE INFORMATION BELOW, I AM GIVING PERMISSION FOR MY CREDIT CARD TO BE CHARGED $50.00 FOR AN UNCANCELLED MISSED APPOINTMENT.

NAME AS APPEARS ON CARD: _____

CREDIT CARD NUMBER: _____ **CVS #** _____

EXPIRATION DATE: _____

SIGNATURE: _____

Email and texting consent

HIPAA regulations and our professional Code of Ethics both require that we keep your Protected Health Information private and secure, and indeed we will do so. Email is a very convenient way to handle administrative issues like scheduling or receipt requests, but email is not 100% secure. Some of the potential risks you might encounter if we email includes:

- Misdelivery of email to an incorrectly typed address.
- Email accounts can be 'hacked', giving a 3rd party access to email content and addresses.
- Email providers (i.e., Gmail, Comcast, Yahoo) keep a copy of each email on their servers, where it might be accessible to employees, etc.

For these reasons, we will not use email to discuss clinical issues, (i.e., the important things we talk about in session.)

If you are comfortable doing so, we are happy to use email to handle small administrative matters like scheduling and billing.

If you are not comfortable with these risks, we can handle administrative issues via phone calls or in person.

I DO DO NOT consent to use email for administrative matters.
(Circle One)

If given, consent will expire 2 years after our last appointment. This means that we will not initiate contact via email after 2 years.

Name: _____ Date: _____

Signature: _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIONS ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your Counselor, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the Counselor's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a Counselor to whom you have been referred to ensure that the Counselor has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining authorization for treatment may require that your relevant protected health information be disclosed to the health plan provider.

Healthcare Operations: We may use or disclosed, as needed, your protected health information in order to support the business activities of your Counselor's practice. These activities include but are not limited to quality assessment, employee review, training of Licensed Professional Counselor Interns, and licensing. For example, we may call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; Organ Donation; Research; Criminal Activity; Military Activity; National Security; Workers' Compensation; and Inmates. Under the law, we must also make disclosures to you, and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your authorization or opportunity to object unless required by lay.

You may revoke this authorization at any time, in writing, except to the extent that your Counselor or the Counselor's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

You have the right to inspect and receive a copy of your protected health information. Our practice will accept such requests in writing. Under federal law, however, you may not inspect or receive a copy of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction on the disclosure of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your Counselor is not required to agree to a restriction that you may request. If a Counselor believes it is in your best interest to permit use and disclosure of your protected health information, your health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by an alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. You have the right to have your Counselor amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will post any changes in our waiting areas. You then have the right to object as provided in this notice.

Complaints

You may file any complaints with our office staff, at 254-xxx-xxxx, or with the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

I,_____ , have read and understand the information contained in the HIPAA Notice of Privacy Practices form.

Initials _____

Please acknowledge your receipt of this Notice of Privacy Practices by signing below.

Client Signature Date

Parent

Notice of Recordings

Counseling sessions are routinely audiotaped in many treatment and training settings, but counselors must obtain a client's permission prior to turning on any recording device. We have the highest regard for the safety of our clients and their confidentiality and will not proceed in recording any session without your prior knowledge and consent.

In addition, we do not consent to clients recording any session during the time of treatment. If you would like to have your session recorded, please address the issue with your therapist and make arrangements.

I,_____, assert that I will not record my therapy sessions during treatment. I also understand that my therapist will inform me of a session being recorded and will obtain written consent prior to recording a session. I understand that I have the right to deny any audio or video recording and I have the right to revoke any prior consent for an audio or video recording.

I have read and fully understand the information contained in this Notice of Recordings Document and I consent to having my sessions recorded.

Client Signature Date

Parent or Representative Signature (relationship) Date