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COUNSELING AGREEMENT

PLEASE READ AND SIGN THE FOLLOWING PRIOR TO SEEING YOUR COUNSELOR

CONFIDENTIALITY

Confidentiality means that therapists have a responsibility to safeguard information obtained during treatment. It is important that you understand that all identifying information about your and/or your child's assessment and treatment is kept confidential, except as noted below. In order to protect your and/or child's confidentiality, you must sign a release of information before any information about you and/or your child is given outside this office.

Should you elect to utilize health insurance (including any form of managed care) for services received, be aware that often insurance and managed care companies require information regarding diagnosis, symptoms, treatment goals, and prognosis about the insured before reimbursement is considered. Such companies may also request a copy of your and/or your child's records.

It is important that you understand that the laws of the State of Texas allow exceptions to confidentiality. In certain situations, mental health professionals are required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, in these situations, I, as your therapist am not required to inform you of our actions. This includes the following:

- Confidentiality does not apply to cases of suspected abuse/neglect of children or the elderly.
- Confidentiality does not apply to cases of potential harm to self or others.
- A mental health professional may disclose confidential information in proceedings brought by a client against a professional.
- Confidentiality does not apply to cases involving criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
- Confidentiality may not apply in cases involving legal proceedings affecting the parent-child relationship.
- Confidentiality may not apply to cases involving a minor child. In such cases, the mental health professional may advise a parent, managing conservator or guardian of a minor, with or without minor's consent, of the treatment needed by or given to the minor.

HEALTH INFORMATION PRIVACY POLICY SUMMARY

The following is a summary of how you and/or your child's protected health information is used and disclosed and how you can obtain access to this information.

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you and/or your child receive. We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required

by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Your Rights as a Client
Although your and/or your child's health record is the physical property of your therapist, the information contained in your and/or your child's health record belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your and/or your child's information
- obtain a paper copy of the notice of privacy practices upon request
- inspect and obtain a copy of your and/or your child's health record
- amend your and/or your child's health record as provided by regulation
- obtain an accounting of disclosures of your and/or your child's health information as provided by law
- request communications of your and/or your child's health care information by alternative means or locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Complaint Regarding the Privacy of Your Health Information
If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your and/or your child's records, you may contact me. You also may send a written complaint to the Department of State and Health Services.

Our Legal Duty Regarding the Privacy of Your Health Information
I am required by law to protect the privacy of your and/or your child's health information, provide this notice about my privacy policy, and follow the information practices that are described in this notice.

THE BENEFITS OF COUNSELING
One major benefit that may be gained from participating in counseling is the resolution of the concerns brought to therapy. Other possible benefits may be a better ability to cope with marital, family and other interpersonal relationships, and /or a greater understanding of personal goals and values.

THE RISKS OF COUNSELING
To allow you to make informed decisions about your counseling, your therapist wishes to make you aware of certain risks involved in counseling. You may experience discomfort, such as anger, depression, or frustration during therapy as you remember and therapeutically resolve unpleasant events. Seeking to resolve concerns between family members, marital partners, and other persons can similarly lead to discomfort as well as relationship changes that may not be originally intended. The greatest risk of counseling is that it may not by itself resolve your concerns. We do our best to assess progress and provide referral to other sources if that is deemed necessary and appropriate.

COST OF SERVICE
The cost of service per therapy hour is $130.00. Should you choose to use health insurance, there may be a set-up fee of $20. Should the fee present an unusual hardship, you may speak with your counselor about this during your initial visit.

PAYMENT OF FEES
All fees for counseling are to be paid when the service is rendered. I accept cash and personal check. Most insurance plans have an annual deductible, which must be met prior to reimbursement. If you have such a deductible, this is your responsibility to pay. Some insurance plans require the insured to call prior to the first visit and obtain authorization for a specified number of visits; and your counselor is not allowed to call for you. If you fail to obtain this authorization prior to your initial counseling session, some insurance companies reduce or decline reimbursement. In this event, you are responsible for payment.

INSURANCE CLAIMS
All services rendered are the financial responsibility of the client or the client's parent or guardian. The client is responsible for the payment regardless of insurance coverage. Billing information will be provided to expedite client reimbursement from private insurance carriers. **Authorization of Payment**: I hereby authorize the provider of services to release information concerning my examination and/or treatment for insurance purposes and to receive direct payment for benefits payable to me for services rendered

CANCELLATIONS
Cancellations must be made twenty-four hours in advance to avoid charge. Missed appointments will be charged at the regular fee.

NSF CHECKS AND REJECTED CREDIT CARD CHARGES
There will be a $35 charge for each NSF check.

WRITTEN ACKNOWLEDGEMENT AND CONSENT TO COUNSELING
I have reviewed this Counseling Agreement, including the summary of Privacy Policy. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

I accept this agreement and herewith consent to counseling.

_____
Client Name (Please Print)

_____
Client or Parent/Legal Guardian/Legal Representative Signature

_____ _____
Printed Name Date

Counselor Signature_____

Printed Name _____

Date_____

Date of form: 20110201 (Rev.)