**Professional Disclosure Statement**

Welcome to Counseling and Wellness of Heath. The following pages contain information about our 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 with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPPA requires that we offer you a copy of Notice of Privacy Practices (the Notice). The Notice explains HIPPA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before the first session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us.

**Benefits and Risks of Therapy**

Research studies repeatedly demonstrate the effectiveness of Individual and family therapy in treating the full range of mental and emotional disorders and health problems. Clients report marked improvement in work productivity, co-worker relationships, family relationships, partner relationships, emotional health, overall health, social life, and community involvement. Other benefits of counseling are improvements in general mood; increased self-esteem and self-confidence; increased ability to set realistic goals and accomplish them; increased ability to manage stressful life circumstances; increased ability to manage strong emotional reactions such as anger, fear, or sadness; increased ability to trust, feel close to, and communicate feelings, thoughts, and needs more openly to others; and an increased ability to stop behaviors that are not serving you well and start engaging in healthier behaviors. A few risks associated with therapy and counseling include: some feelings or behaviors may seem to get worse, especially in the beginning; important people in your life may not support your decision to be in therapy; and you may develop strong positive feelings for your counselor and feel sad or distressed when therapy ends. Effective therapy is sometimes uncomfortable as sensitive issues may need to be explored or challenged. You are strongly encouraged to discuss any fears, concerns, or doubts you have with your counselor, including specific risks and benefits not listed that may be associated with your situation. Every effort will be made to support your personal needs.

**Scheduling Appointments**

Initial appointment inquiries are made by calling Counseling and Wellness of Heath at 972-742-7038 or by contacting your therapist directly via email or phone. The time and day of appointments can be coordinated through phone, email, or at the end of your sessions. We require a 24 hour notice if you need to cancel or reschedule your appointment. Please contact your therapist directly regarding any schedule changes.

**Court Proceedings**

If the therapist appears in court related to your treatment, or in the case of being called as a witness or expert witness, the hourly rate will be $250 dollars with a minimum of 4 hours. This rate will be applied to preparation time with attorney(s), investigators, or other court personnel, time printing or preparing records which have been subpoenaed, therapist time reviewing records, time spent traveling to and from the court, and all activities between departure for the appearance and return to the office, including time spent waiting for proceedings. The therapist also requires a therapeutic relationship with a minimum of 4 sessions prior to being called in civil cases.

**Requests for Legal Letters**

For example, emotional support animal (ESA), custody, ability to appear, FMLA or any letter to be written on behalf of the client for legal or employment purposes (excluding a school/work excuse note). The therapist requires a therapeutic relationship of at least 4 sessions to be able to fully assess the need of the client, and the letter is not a guarantee. The fee for writing a legal letter on behalf of the client is $70.00, and requires a written request with 2 weeks notice.

**24 Hour Cancellation Policy**

Your appointment time is reserved *exclusively for you*. **Appointments cancelled or rescheduled with less than 24 hours’ notice will be charged at the regular session rate.** I authorize the therapist to charge my card for my late cancellations or therapy services, should it become necessary:

**\_\_\_\_\_\_\_\_\_\_\_ Initial here that you have read and agree to the late cancelation policy.**

**Afterschool/Evening Appointments**

If your appointment is a reoccurring appointment scheduled during peak hours from 3:00pm-8:00pm, Monday through Friday, these appointments will be forfeited if there are 3 or more cancellations or late arrivals. This includes cancellations made before the 24 hour cancellation period. Please do not hesitate to discuss if the reoccurring time originally agreed upon does not work for your schedule any longer. The therapist will not hesitate to try to accommodate you, if possible.

**\_\_\_\_\_\_\_\_\_\_\_ Initial here that you have read and agree to the afterschool/evening policy.**

**Request for Superbill**

The client can request from their therapist a superbill to submit to their insurance for possible out-of-network reimbursement. The superbills are generated around the 5th of each month. Please note that anything submitted to your insurance for reimbursement will require a diagnosis on your electronic records.

**Cessation of Therapy**

The therapist and client will make periodic re-evaluations to assess the efficacy of therapy. The client has the right to stop therapy at his/her discretion, at any time. The therapist also reserves the right to stop therapy at his/her discretion, for reasons including but not limited to untimely fee payment, noncompliance with treatment recommendations, conflict of interest, failure to participate in therapy, or client’s needs being outside the therapist’s scope of practice or competence. Upon either party’s decision to discontinue therapy, therapist will usually recommend that the client participate in at least one concluding session to facilitate a positive concluding experience and allow both parties to reflect on the work that has been done. The therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to client. If you have any complaints about your therapist’s service, we invite you to discuss them with your therapist at once. This process may enhance the counseling process as well as your progress. If you would like to make a formal complaint, please contact: *Texas State Board of Social Worker Examiners*, *Complaints Management and Investigative section, P.O. Box 141369 Austin, Texas* 78714-1369 or call 1-800-942-5540.

**Record Retention & Confidentiality**

Pursuant to HIPPA, Counseling and Wellness of Heath practitioners keep PHI about you in professional progress records which are collectively referred to as you the Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. CWH will retain client records for a minimum of five years for adult clients and 5 years beyond the age of 18 years of age for a minor at which time it will be disposed of in such a way that confidentiality will be maintained. CWH reserves the right to deny your record request if there is substantial reason to believe that having a written copy of the record could be of detriment to you personally. However, if copies of records are obtained, the copy cost is $3.00 per page, payable upon receipt.

Perhaps the most critical factor in a therapeutic relationship is confidentiality. Much of what you may wish to share with your therapist is very personal. We, as health care professionals, affirm your right to privacy. Information shared during a counseling session can only be shared with an appropriate outside party(s) if one or more of these criteria are met:

1. You sign a written release of information permitting such disclosure.
2. You are assessed as being potentially harmful to yourself or others.
3. You are assessed as being emotionally disturbed to the point of being unable to care for yourself.
4. You reveal current information about abuse or neglect of a child, a disabled person or an elderly person.
5. In the case of a minor, the parents or legal guardians will be notified of any life-threatening or illegal activity that is reported to the practitioner.
6. Records are ordered by a court of law.
7. A summary of records is requested by your insurance company or managed care company.
8. If it is reasonable and necessary for the practitioners at CWH to discuss clinical information specific to your case in order to provide the most effective help for you, the practitioners will share information with one another.

**Counseling Relationship**

Typically, a counselor will allot approximately 45-50 minutes for each session. During sessions, the primary goal is to establish a trusting relationship that is honest and genuine in nature and purposed for the client’s individual growth and positive change in emotional well-being. Sessions utilizing EMDR might be extended based on the need of the client, and the fee adjusted to reflect the time. Included in your session fee is limited email support between sessions or various questions that might arise. At therapist’s discretion, a response will be provided or the email will be discussed in the next session.

**After Hours Policy/Procedure**

If you need to contact your therapist at any time, you may do so by leaving a message on the confidential voice mailbox of CWH or by contacting your therapist directly on the number they provide for you. CWH is not a crisis facility and will not be held responsible for any damages occurring as a result of unmet crisis or acute care needs. Your therapist may not be available to respond to emergency situations*.* ***If you are in crisis, please call 911 or go to your nearest hospital emergency room.***

**Statement of Confidentiality & Policy Agreement**

I understand that Counseling and Wellness of Heath offers confidential counseling in so far as allowed by the laws of the State of Texas. I understand that if my practitioner believes there exists a threat of imminent and specific harm to myself or others, my right to confidentiality may be necessarily and legally violated. By signing below, I am indicating that I have read these conditions and fully understand and agree with this Statement of Confidentiality.

By signing below, I am also indicating that I have read and agree to abide by the policies and procedures outlined in this packet. I do hereby consent to treatment and agree to make payments as outlined above.

**Client Fees**

Each session will last 45-50 minutes. Some younger children may not be able to tolerate a 45 minute session, therefore times will be formatted to fit those Individual needs and will be discussed with you by your therapist. You are expected to pay for each visit at the time the service is rendered. Payment may be made by check, cash or debit/credit. Fees are as follows:

60 minute initial session (play, teen, adult): $130 45-60 minute individual session (play, teen, adult): $130

50-60 minute caregiver consultation (play): $130 60 minute family (2 or more family members) session: $130

90 minute family (2 or more members) session: $190 60 minute EMDR: $150, plus $50 for each additional 30 min.

CARD NUMBER: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

EXPIRES: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CV (3 numbers on back of card):\_\_\_\_\_\_\_\_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME AS IT APPEARS ON CARD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agreement for Telehealth Services**

The therapist offers in-person and telehealth sessions or a combination of both. Please initial where indicated below if you choose telehealth counseling services or in the event you might need to utilize telehealth in the future.

**Technology:  \_\_\_\_\_\_\_\_ (Initial)** I agree that I have experience with using technology and that I will maintain up-to-date Internet services on my chosen device for connection.  I agree that I will install and use Google Chrome or supported browser for distance counseling.

**Privacy:  \_\_\_\_\_\_\_ (Initial)** I agree to maintain a private space for the counseling session to take place with little/no disruptions.

**Location:  \_\_\_\_\_\_\_ (Initial)** I agree that the active client and guardian will be physically within the state of Texas during the distance counseling session.  If I am not within the state of Texas, the session will be rescheduled.

**Recording:  \_\_\_\_\_\_   (Initial)** I agree that I will **NOT** use any technology to record a distance counseling session. The therapist will not record any distance counseling sessions.

**Adult Presence:  \_\_\_\_\_\_\_\_ (Initial)** I agree that I will stay physically onsite during the distance counseling session or I will designate a responsible adult over the age of 18 years old to stay on site during my child’s session.

**Emergency Contact:  \_\_\_\_\_\_\_ (Initial)** I agree that I will provide an emergency contact name and phone number who is either on site of the distance counseling or within 50 miles of the client’s location.

I have read and understand the above information and agree to voluntarily enter myself and/or my child into counseling services with Megan R. Young, MSW, LCSW.  I further understand the limits of confidentiality and understand that those limits also apply in the case of a minor.  If I am the legal conservator or guardian of a minor, my signature below indicates my consent to their treatment.  I have been given a copy of the Informed Consent document for my records.

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Client name (printed) Date

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Client signature Date