

Informed Consent for Career Counseling

Eddins Counseling Group

1. **Career counseling** is a collaborative process intended to assist you with addressing current career concerns and refining skills for developing your own career.
2. **Time Parameters:** Individual appointments are scheduled for 45-minute segments. *Being late for an appointment by 20 minutes or more may require that you reschedule.*
3. **Confidentiality:** As a Licensed Professional Counselor in the State of Texas, I am bound by the Texas Administrative Code, Chapter 681 and the Health and Safety Code, Chapter 611. In accordance with these rules, information obtained in the counseling session or in written form will **not** be disclosed to any outside person(s) or agency without your written permission except when such disclosure is necessary to “protect you or someone else from imminent harm” or is otherwise legally required and/or allowed by law (such as abuse of a child, elder, or disabled person or court order). If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize release to other parties.
4. **Electronic Transmission:** I cannot ensure the confidentiality of any form of communication through electronic media. You are advised that any email sent to me via a computer in a work-place environment is legally accessible by an employer.
5. **Records:** I am required by law to maintain records of each time we meet or talk on the phone. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting.
6. **Consultation:** Information about you may be discussed in confidence, without revealing your identity, with other career professionals for the purpose of consultation and providing you the best possible service.
7. **Fees and Payment** will be collected at the time of service.
8. **Cancellation:** If you find it necessary to cancel an appointment, please contact the receptionist at 832-209-2222 or your counselor at least 24 hours in advance. ***Cancellations with less than 24 hours advance notice will be charged a \$60 no-show fee. PLEASE INITIAL HERE THAT YOU UNDERSTAND THIS POLICY*** _____.

I have read, understood, agree, and consent to the above conditions of service stated. I have also received the notice of privacy practices on this date.

Client Signature

Date

***If you are under age 18, I must have your parent's permission for you to receive counseling and assessment.*

I hereby grant permission to _____ to counsel/assess my child, _____

Parent Name

Parent Signature

Date

NOTICE OF PRIVACY PRACTICES – EDDINS COUNSELING GROUP

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

This Notice is effective as of March 29, 2005.

I am required by applicable federal and state law to maintain the privacy of your health information and inform you of my privacy practices, legal obligations, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

I am required to abide by the terms of the Notice of Privacy Practices that is most current. I reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that I maintain. The revised Notice will be posted in the waiting room. You may request a copy of the revised Notice at any time.

I will answer your questions about my privacy practices and do ensure that I will comply with applicable laws and regulations. I will also take your complaints and can give you information about how to file a complaint.

I. USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION THAT MAY BE MADE TO CARRY OUT HEALTHCARE OPERATIONS.

I may use and disclose limited information from your record without your written authorization, excluding Counseling Notes as described in Section IV, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

Treatment: I may use and disclose limited information in order to provide treatment to you. For example, I may use information to diagnose and provide counseling service to you. In addition, I may disclose information to other health care providers involved in your treatment.

Payment: I may use or disclose limited information from your record to obtain payment for the services you receive. For example, I may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

Health Care Operations: I may use and disclose information from your record to allow health care operations including quality improvement activities, training programs, reviewing records to see how care can be improved, accreditation, certification, licensing or credentialing activities. For example, I may use information in your record to train another counselor.

II. YOUR INDIVIDUAL RIGHTS

Right to Inspect and Copy. You may request access to the information in your record maintained by me in order to inspect and make a copy of it. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested.

Right to Request Restrictions. You may ask to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment or payment. You must request any such restriction in writing. I am not required to agree to any such restriction you may request.

Right to Accounting of Disclosures. You have the right to request an accounting of any disclosures made by me after March 29, 2005.

Right to Request Amendment: If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

Right to Obtain Notice. You have a right to obtain a paper copy of this Notice upon request.

Right to Complain. You have the right to complain to us about our privacy. You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

Except as described in this Notice, I may not make any use or disclosure of information from your record unless you give me your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

III. USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION THAT I AM REQUIRED TO MAKE WITHOUT YOUR PERMISSION.

Communications between a counselor and client are privileged and may not be disclosed without your permission, except as required by law. For example, counselors must report suspected abuse/neglect of a child, elder, or disabled person. I may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others. Also, I must disclose information to the Department of Health and Human Services, if requested, to prove that I am complying with regulations that safeguard your health information.

I may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, I may disclose information in response to a subpoena or other legal process, even without a court order.

You have a right to receive confidential communications from me. For example, if you want to receive bills and other information at an alternative address, please notify me. I may contact you to provide information or appointment reminders as a courtesy. Please notify me if I am not to leave a telephone message or use electronic communication. You are responsible for remembering your appointment, whether or not you receive a reminder.

I may contact you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.

IV. USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Counseling Notes: Notes recorded by your counselor documenting the contents of a counseling session with you ("Counseling Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

Marketing Communications: I will not use your health information for marketing communications without your written authorization.

Other Uses and Disclosures: Uses and disclosures other than those described in Section I & III above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send information to a school, or to your attorney. You may revoke any such authorization at any time.

