

## Office Policies & Informed Consent for Counseling

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This form provides you with information that is in addition to that detailed in the Notice of Privacy Practices.

- Counseling** is a collaborative process between you and a counselor to work on areas of dissatisfaction in your life and assist you with life goals. For counseling to be most effective, it is important that you take an active role in the process. Counseling activities are governed by the Texas State Board of Examiners for Professional Counselors. I do not take on clients I do not think I can help. Therefore, I will enter our relationship with optimism about our progress. I do not provide custody evaluation recommendation, nor medication or prescription recommendation, nor legal advice, as these activities do not fall within my scope of practice.
- 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.*
- 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 or neglect of a child under 18, elder, or disabled person. I may also be required to provide information to the court if provided a court order. If a client files a worker’s compensation claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought. If any of the above situations arise, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize release to other parties. If I run into you outside of the counseling office, I will protect your confidentiality and wait for you to acknowledge me should you choose to do so.
- Risks:** In counseling, major life decisions are sometimes made, including decisions involving separation within families, development of other types of relationships, changing employment settings and changing lifestyles. The decisions are a legitimate outcome of the counseling experience as a result of an individual’s calling into question many of their beliefs and values. Furthermore, symptoms may be intensified and the emotional experience may be too intense to deal with at this time. I will be available to discuss any of your assumptions or possible negative side effects in our work together. There is no guarantee of what you will experience in counseling.
- Cancellation:** If you find it necessary to cancel an appointment, please contact the receptionist at 832-209-2222 or your counselor at least 24 business hours in advance. ***Cancellations with less than 24 hours advance notice will be charged a \$60 no-show fee.*** The provider may also terminate counseling in the event the client has missed 3 appointments without calling to cancel 24 hours prior to the scheduled appointment. **PLEASE INITIAL HERE THAT YOU UNDERSTAND THIS POLICY**.
- Emergencies:** If an emergency situation for which you feel immediate attention is necessary, please contact emergency services (911) immediately, the 24-hour MHMRA Helpline, 713-970-7000, who will determine the need to go to the Psychiatric Emergency Service located at 1501 Taub Loop in the Texas Medical Center (24-7 walk-ins), or go to your nearest hospital emergency room. I will follow those emergency services with standard counseling and am available to be paged at 832-338-6863 – please indicate when a call is urgent as calls are returned during normal business hours. Keep in mind that while I may be in the office I do not answer the phone while in session with a client. If I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can, within the limits of the law, to prevent you from injuring yourself others and to ensure that you receive the proper medical care. Texas law provides that a professional may disclose confidential information only to medical or law enforcement personnel if the professional determines that there is a probability of injury to self or others. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary. Please do not use e-mail and faxes for emergencies.

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7. **Fees and Payment** will be collected at the time of service; cash, check, Visa, MC, AMEX or Discover are acceptable forms of payment. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc... will be charged at the standard rate in the payment contract for services, unless indicated and agreed upon otherwise. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, I will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose. You must be aware that not all issues/problems dealt with in counseling are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.
  
8. **Health Insurance & Confidentiality of Records:** If you want your EAP or insurance to pay for all or part of your treatment, I must be able to discuss your diagnosis and treatment with their representative. I have no control or knowledge over what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk of confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into an insurance database and reported to the National Medical Data Bank. Accessibility to computer systems is always in question as computers are inherently vulnerable to unauthorized access. Medical data has also been reported to be legally accessed by enforcement and other agencies.
  
9. **Consultation:** Information about you may be discussed in confidence, without revealing your identity, with other counseling professionals for the purpose of consultation and providing you the best possible service.
  
10. **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. I do not always check email daily.
  
11. **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. A judge can subpoena your records for a variety of reasons, and if this happens, I must comply. I can be called to testify about the contents of the records and I must comply. Also, in order to file for insurance reimbursement, I have to assign you a diagnosis. If you have any questions about this, please let me know. I will certainly share any information with you that I provide to an insurance provider.
  
12. **Litigation Limitation:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to the many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc...), neither you (client's) nor your attorney's, nor anyone else acting on your behalf will on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.
  
13. **Termination:** If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and if I have your written consent, will provide him or her with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, I will offer to provide you with names of other professionals whose services you might prefer.

**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 and have had the opportunity to ask questions about and understand these policies.**

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Client Signature \_\_\_\_\_

Date \_\_\_\_\_

(\*\*For Minors Only) I hereby grant permission to Rachel Eddins to counsel/assess my child, \_\_\_\_\_

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Parent Signature \_\_\_\_\_

Parent Printed Name \_\_\_\_\_

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.

