Guadalupe "Lupe" Garcia, LPC, NCC
Garcia Counseling, PLLC
Pearland Counseling Center
2217 Park Ave. Pearland, TX 77581
(281) 997-8400

OFFICE INFORMATION AND POLICIES

I am pleased that we will be working together and am committed to helping you reach your goals in counseling. This document is designed to inform you of my professional background and business policies. I am a Licensed Professional Counselor (LPC) and Licensed Mental Health Counselor (LMHC) in the state of Florida. I received my master's degree in mental health and school counseling from Florida International University. I am an independent private practitioner at Pearland Counseling Center.

Goals of Therapy: Counseling is a process whereby the counselor guides you to help yourself with the problems you are experiencing. Together, you and the I assess your problems and establish goals for counseling. I will not make decisions for you, but will facilitate you reaching your goal. Counseling may be beneficial for most people while at the same time there are risks. The risks may include 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.

Length of Counseling: Each client will have different concerns to address in counseling so there is no set number of sessions you will need to attend. You and I will decide, as you progress, how often you should attend counseling. Termination of counseling may happen at any time and may be ended by you or I. If you are ready to terminate therapy, please allow at least one session for closure.

Confidentiality & Code of Conduct: Communication between a client and a counselor is confidential to the extent of the law. However, there are certain situations that require only that you provide written, advance consent for the release of information concerning what you say in a counseling session. Your signature on this Agreement provides consent for the following activities:

- Processing by administrative staff. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling and/or billing.
- Disclosure required by insurance companies that includes a DSM-5 diagnosis.
- Serious danger to yourself or others. If a client seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. 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 imminent physical injury to the patient or others, or there is a probability of immediate mental or emotional injury to the client.

In the event that I reasonably believe that you are a danger, physically or emotionally, to yourself or another person, you specifically consent for me to contact the following individuals, in addition to medical and law enforcement personnel:

Name & relationship _____ Phone # _____

Name & relationship _____ Phone # _____

Name & relationship _____ Phone # _____

- If a client files a complaint or lawsuit against me, I will disclose relevant information regarding that client in order to defend myself.
- I do not accept friend requests from current or former clients on my psychotherapy related profiles or social networking sites due to the fact that these sites can compromise clients' confidentiality and privacy. For the same reason, I request that clients do not communicate with me via any interactive or social networking websites.

Disclosure will not be affected by this agreement in the following situations:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and therapy, such information is protected by law. I cannot provide any information without your written authorization, or a court order.

In certain situations I am legally obligated to take action, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's therapy. If such a case should 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. Such a situation would be:

- If I have cause to believe a child under the age of 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense the law requires that I make a report to the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information.
- If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that I make a report to the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information.

Client Responsibilities: You, the client, are a full partner in counseling. Your honesty and effort is essential to success. If, as we work together, you have suggestions or concerns about your counseling, it is important that you share these with me so that we can make the necessary adjustments. I will help with a referral process if it is identified that you would be served better by another mental health provider. If you are currently receiving services from another mental health professional, I request that you inform me of this and grant me permission to share information with this professional so that we may coordinate our services to you. I also expect you to follow office procedures for keeping/canceling appointments, as well as payment for services when rendered.

Potential Counseling Risk: Although psychotherapy is extremely beneficial, there are still risks associated. These risks may include unwanted feelings of fear, anger, sadness, distress, guilt, anxiety, or additional strain placed on an individual. These feelings, associated with change, are a normal part of the therapy process. Therapy often requires self-examination, reviewing previous painful experiences, and wrestling with difficult thoughts. Therapy may also involve life decisions such as seeking new employment, ending or beginning relationships, etc. Please be encouraged to know that I am open to discussing any concerns regarding the therapy process.

Appointments and Messages: Appointments and messages are primarily conveyed via the administrative staff at the Pearland Counseling Center. They can be reached at (281) 997-8400 and are available Monday through Thursday from 9am to 7pm, and Friday from 9am to 5pm. Messages may be left 24 hours a day, seven days a week. Calls are recorded by a confidential voice mail system and are returned as soon as possible. To facilitate this, the caller needs to leave a daytime/evening phone, or cell number along with current concerns. Please call 911 in case of an emergency.

All counseling services are by appointment only. The length of the counseling sessions are usually 45-50 minutes, or what is known as a clinical hour. Because an appointment is reserved for you, it is required that you let us know by 1:00 pm the day prior to your appointment if you must cancel your appointment.

*** You are financially responsible for the session missed unless you have given the proper notice.***
No show or No call is a fee of $80.00.

Fees: My cash rate fee for 45-50 minute psychotherapy sessions are $80.00. Rate subject to increase with notice of changes. In addition to weekly appointments, I charge $30 for other professional services such as telephone conversations lasting more than 15 minutes, consulting with other professionals, and time spent performing any other service you may request of me.
In the event there are three sessions cancelled late or not shown up to, all future scheduled appointments will be cancelled. The no show or late cancellation fee must be paid before the next scheduled session. This fee is not covered by insurance at this time.

Payment is expected before each session at the time it is held, unless we agree otherwise. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, future scheduled sessions will be cancelled until payment is received.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. You will also be responsible for my legal representative's fees. I charge $600.00 per hour for my involvement at any legal proceedings. If I go to court to testify, you agree to pay 24 hours in advance either $1,000 for half a day: 8:00AM-12:00PM or $2,000 for an entire day. If the duration of my professional involvement continues after six months, my fees are subject to increase by 20%. This fee is not covered by insurance.

Telehealth: At times it may become necessary to use video-conferenced therapy ("telehealth"). To participate in telehealth, you authorize information related to your mental health and health care to be electronically transmitted in the form of images and data through an interactive, encrypted, HIPAA compliant video connection to and from myself, the provider, and other persons involved in your health care. You are also expected to use your own equipment to communicate and not equipment owned by another, and specifically not using your employer's computer or network.

It has been explained how the telehealth sessions is performed, and how it will be used for treatment. It has also been explained how the session(s) differ from in-person services, including but not limited to emotional reactions that may be generated by the technology. In brief, you understand that I will not be physically in your presence. Instead, we will see and hear each other electronically. Some information that would ordinarily be available to me in face-to-face sessions may not be available in telehealth. It is important you understand that such missing information could in some situations make it difficult to understand your problems and to help you get better.

Telehealth sessions are a relatively new form of treatment, in an area not yet fully validated by research, and that there are potential risks, possibly including some that are not yet recognized. Among the risks that are presently recognized are the possibility that the technology will fail before or during the scheduled telehealth session, that the transmitted information in any form will be unclear or inadequate for proper use, and that the information could be intercepted by an unauthorized person or persons.

At any time, the telehealth session(s) can be discontinued either by you or me. Furthermore, you do not have to answer any question that you feel is inappropriate or whose answer you do not wish persons present to hear, that any refusal to participate in the telehealth session(s) will not affect your continued treatment, and that no action will be taken against you. Please acknowledge, however, that treatment depends on information, so if you withhold information, you assume the risk that your treatment might be less successful than it otherwise would be, or it could fail entirely.

Telehealth session(s) does not necessarily eliminate your need to see a specialist in person. There is no guarantee as to the telehealth session's effectiveness. You can still pursue in-person sessions. You unconditionally release and discharge me, my affiliates, agents, or designees from any liability in connection with your participation in the telehealth sessions.

It is important you have a copy of my contact information. It may become necessary to contact the proper authorities in case of an emergency. If you are facing or if you think you may be facing an emergency situation that could immediately result in harm to yourself or to another person, you are not to see a telehealth session. Instead, seek care immediately through the nearest hospital emergency department or by calling 211 or 911.

Records Request:
We make every effort to keep your mental health records secure per HIPAA (Health Insurance Portability and Accountability Act) and the Texas Health and Safety Code regulations.
To request a copy of your (the clients) mental health records:

1) Request a copy of your mental health records/documents in writing. If you mail your request, address the request to your therapist at 2217 N. Park Avenue, Pearland, TX 77581. Please print and sign your name on the request.
2) Please be aware your request for a copy of your records or a copy of documents from your records can be denied.
3) Your therapist has up to 15 days after receipt of your request to provide the requested documents or provide a denial of the request.
4) There may be a fee charged for the requested mental health records/documents.

Complaint Process: An individual who wishes to file a complaint against a Licensed Professional Counselor may write to:

Texas Behavioral Health Executive Council

333 Guadalupe St., Ste 3-900

Austin, Texas 78701

1-800-821-3205

Please see "Notice of Privacy Practices" brief version for additional information located in your introduction packet. A long version of the Notice of Privacy Practices is available upon request and is also posted in the waiting room.

CLIENT REGISTRATION PAGE

TODAY'S DATE: _____

Patient Name: _____ DOB: __ __ - __ __ - __ __ __ __ Age: ___ Gender: ___

Marital Status: **SINGLE MARRIED DIVORCED WIDOWED** SS#: __ __ __ - __ __ - __ __ __ __ DL#: __ __ __ __ __ __ __ __

Address: _____ APT#: _____

City: _____ State: _____ Zip: _____

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

May we contact your home #? _____ May we contact your work #? _____ May we contact your cell #? _____

May we leave a message? Y N May we leave a message? Y N May we leave a message? Y N

E-Mail Address: _____

Employer: _____ Occupation: _____

Emergency Contact

Name: _____ Relationship: _____

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

Name of person responsible for this client: _____ Relationship: _____

INSURANCE INFORMATION

Name of Insured person: _____ Relationship: _____

Insured SS#: __ __ __ - __ __ - __ __ __ __ Insured DOB: __ __ - __ __ - __ __ __ __ Gender: _____

Insured Employer: _____ Employer Phone #: __ __ __ - __ __ __ - __ __ __ __

Name of Insurance: _____ Insurance Phone #: __ __ __ - __ __ __ - __ __ __ __

ID or Policy #: _____ Group #: _____

ADDRESS AND CONTACT INFORMATION OF INSURED PERSON, *IF NOT THE SAME AS CLIENT*

Address: _____ APT#:_____

City: _____ State: _____ Zip: __ __ __ __ __

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

MEDICAL HISTORY

Reason for seeking Counseling: _____

_____

Other physicians treating you: _____ Phone #: __ __ __ - __ __ __ - __ __ __ __

Other physicians treating you: _____ Phone #: __ __ __ - __ __ __ - __ __ __ __

Other physicians treating you: _____ Phone #: __ __ __ - __ __ __ - __ __ __ __

Current physical problems (describe): _____

_____

Current Medications: _____

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Upon complete review of all documents in this packet, pages 1-13, your therapist will provide an Acknowledgement and Consent form to be signed by you (the client) and your therapist during the initial sessions.

I (the client) understand that pages 1-13 (Excluding Signature Page 6) of this packet are available to me anytime online at www.pearlandcounselingcenter.com or by request. This request can be made in person at Pearland Counseling Center, 2217 Park Avenue, Pearland, Texas 77581.

I (the client) understand that my signature is required on the Acknowledgement and Consent form before services can be provided. I (the client) understand that **if I choose NOT to sign the Acknowledgement and Consent form counseling services will not be provided.**

IMPORTANT: It is required the Acknowledgement and consent for is signed by you (the client) and witnessed prior to the start of counseling services.

NOTICE OF PRIVACY PRACTICES (NPP) – BRIEF VERSION

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.

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This information is a shorter version of the full, legally required NPP which is available upon your request and contains more information regarding your protected health information. Please talk to your Privacy Officer (see the end of this pamphlet) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records but we may charge you. We will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another within 12 months. Contact your Privacy Officer to arrange how to see your records. See below.

4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to your Privacy Officer. You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy of the NPP from your Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with your Privacy Officer Guadalupe Garcia, LPC, NCC at 2217 Park Avenue, Pearland, TX 77581. All complaints to our Privacy Officer must be in writing. You can also file a complaint with the Secretary of the Department of Health and Human Services Office for Civil Rights at 200 Independence Ave., S.W. Washington, D.C. 20201, or by calling 1-877-696-6775 or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact your Privacy Officer who is Guadalupe Garcia, LPC, NCC and can be reached by phone at 281-997-8400.

All privacy and security questions, requests, and concerns should be directed to me, Guadalupe Garcia, and I will be responsible for handling them.

Acknowledgement of Receipt of Notice of Privacy Practice

I, _____, have read and understand this document. 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 practices and policies delineated herein and have received a copy of this Office's Notice of Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

It is your right to refuse to sign this document.

For Office Use Only:

The reason that a standard acknowledgment (such as the above) of the receipt of the Notice of Privacy Practices was not obtained:

_____ Patient refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented this office from obtaining it.

_____ Others: _____

Email and Texting Consent

HIPAA regulations and my professional Code of Ethics both require that I keep your Protected Health Information private and secure, and indeed I want to 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 include:

- 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, and Yahoo) keep a copy of each email on their servers, where it might be accessible to employees, etc.

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

If you are comfortable doing so, I am happy to use email to handle small administrative matters like scheduling and billing. This will only be utilized if the Office Staff is unavailable to assist you with these matters.

The Office Staff will handle all scheduling, billing and other office matters by phone only. Email and text will not be used as a form of communication. If this policy changes, you will be notified at the time of change and be provided with an updated consent to review and sign.

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

I do not text clients appointment confirmations.

Please indicate your preference about email below and sign. (CIRCLE ONE)

I DO or DO NOT consent to use email for administrative matters.

If given, consent will expire 2 years after our last appointment. This means that I will not initiate contact via email, although you are always still welcome to email me, and I can reply briefly if you do.

Printed Name: _____

Signature: _____ Date: _____

SOCIAL MEDIA

Social media is used for personal use only and should not be used in professional relationships. In order to respect the boundaries of both the clients and the staff, including maintaining confidentiality, there can be no affiliation on these websites.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client's Initials: _____ Parent/Guardian Initials (If client is under 18 years old): _____ _____

INSURANCE – ASSIGNMENT AND RELEASE

I the undersigned certify that I (and/or my dependents) have insurance coverage with _____ and that I assign directly to Guadalupe Garcia, LPC, NCC all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize Guadalupe Garcia, LPC, NCC to release any information necessary to secure payment of benefits. I authorize this signature on all insurance submissions.

Client's Initials: _____ Parent/Guardian Initials (If client is under 18 years old): _____ _____

POLICY FOR PROVIDING NEW INSURANCE INFORMATION

Our clients are very important to us and our main goal is make their time here as pleasant and smooth as possible. It is pertinent that we receive any updated information prior to your scheduled appointment so that we are able to avoid any discrepancies with your insurance coverage.

If/when you acquire new insurance, we require a 48 HOUR NOTICE prior to your scheduled appointment. If you do not provide your updated insurance information within the 48 hour timeframe you will be subject to a fee. The fee will be based on the contracted rate of your insurance company.

I understand that I will be responsible for any fees and/or balances owed on my account if I do not provide my new insurance information within the required time period. This includes claims that are denied.

Client's Initials: _____ Parent/Guardian Initials (If client is under 18 years old): _____ _____

Print Name: _____

Signature: _____ Date: _____

POLICY FOR NO SHOW/LATE CANCEL AND OUTSTANDING BALANCE DUE

We are very committed to serving our clients and strive to accommodate all of 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 the 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 our office manager.

****

I understand that I will be responsible for a **missed appointment fee of $80.00** and that my credit card will be charged if I am unable to provide the proper notice that I will not keep my scheduled appointment.

I also understand that I will be responsible for any outstanding balance for services rendered and that my credit card will be charged to pay for the outstanding balance.

If you choose to provide your flexible spending account information, an additional credit or debit card number is required as the situation may occur that your flex account holds insufficient funds or its balance has become depleted.

We accept the following debit/credit cards: Visa, Discover, American Express and MasterCard.

FOR FLEX CARD:

Name As Appears On Card: _____

Credit Card Number: ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____

Expiration Date: _____

FOR CREDIT/DEBIT CARD:

Name As Appears On Card: _____

Credit Card Number: ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____

Expiration Date: _____

I have read, understand and agree to the Policy above and give my permission for my card to be charged if a violation occurs.

Print Name: _____

Signature: _____ Date: _____

I _____ (CREDIT CARD HOLDER NAME) understand that by providing my Credit Card information I am consenting to being financially responsible for

_____ (CLIENT NAME) regarding any violation of the Policy stated above.

Print Name: _____

Signature: _____ Date: _____

You may revoke this consent at any point, by submitting a request in writing which MUST include: Date of request, client's name, your name, signature, copy of your current Driver's License, and an explanation of the information to be removed. If you are mailing your request, please keep in mind there could be charges to your card until your request is received by our office.

OFFICE USE ONLY: DATE OF REVOKE REQUEST _____ DATE REQUEST REC'D (EFF. DATE OF REVOKE) _____

SELF-ASSESSMENT & CONCERNS

What is happening in your life which resulted in this appointment? _____

_____

What would you like to see accomplished in therapy? _____

_____

CHIEF COMPLAINT (CHECK ALL THAT APPLY TO YOU):

__ Depression
__ Low Energy
__ Low self-esteem
__ Poor concentration
__ Hopelessness
__ Worthlessness
__ Guilt
__ Sleep disturbance (more/less)
__ Appetite disturbance (more/less)
__Thoughts of hurting yourself
__ Thoughts of hurting someone
__ Isolation/social withdrawal
__Sadness/loss
__Stress
__ Anxiety/panic
__ Heart pounding/racing
__ Chest pain
__ Trembling/shaking
__ Sweating
__ Chills/hot flashes
__ Tingling/numbness
__ Fear of dying
__ Fear of going crazy
__ Nausea
__ Phobias
__ Obsessions/compulsive behaviors
__ Thoughts racing
__ Can't hold onto an idea
__ Easily agitate
__ Excessive behaviors (spending, gambling)
__ Delusions/hallucinations
__ Not thinking clearly/confusion

__ Feeling that you are not real
__ Feeling that things around you are not real
__ Lose track of time
__ Unpleasant thought won't go away
__ Anger/frustration
__ Easily agitated/annoyed
__ Defies rules
__ Blames others
__ Argues
__ Excessive use of prescription medications
__ Blackouts
__ Physical abuse issues
__ Sexual abuse issues
__ Spousal abuse issues
__ Other problems/symptoms:
_____
_____

Number of marriages _____ Number of years married _____

Number of children ___ Ages and Gender _____ _____ _____

Number of step-children ___ Ages and Gender _____ _____ _____

Do you use alcohol? _____ If yes, how much per week? _____

_____

Please look back over the concerns you have checked off and choose the three that you are most concerned with. In order of importance, they are:

1. _____
2. _____
3. _____