BLUE HORIZON COUNSELING

Heather Dunn, MA, LPCS, LMFTS
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2217 Park Ave, Pearland TX 77581
www.pearlandcounselingcenter.com

Consent for Services

My name is Heather Dunn, MA, Licensed Professional Counselor Supervisor, Licensed Marriage and Family Therapy Supervisor, Cognitive Processing Therapy Provider and EMDR Approved Consultant and Trainer in Training.

ETHICS
I adhere to the Code of Ethics of the American Counseling Association (ACA) as well as the state rules governing Licensed Professional Counselors and Licensed Marriage and Family Therapists.

______ **THERAPEUTIC SERVICES**
Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience feelings such as sadness, guilt, anger, frustration and helplessness. For those that continue in the process, psychotherapy has been shown to have benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

At all times our relationship will remain professional. Over time a natural emotional intimacy will occur and will play a significant role in your healing. However, dual relationships are prohibited; at no time will our professional relationship become personal. If a potential dual relationship is discovered, we will discuss options as to how to move forward.

______ **MEETINGS**
During the first couple of sessions we will get to know each other. We will both decide if our relationship is the best fit to meet your treatment goals. Please let me know of any concerns.

Sessions are typically 50 minutes long. Once an appointment is scheduled, you will be expected to participate in that session, or provide a 24 hour notice of cancellation. Failure to give adequate notice or miss your appointment will result in a missed appointment fee of $75.

______ **PROFESSIONAL RECORDS**
The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records or a summary of your sessions. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, it is recommended that we review them together to discuss the contents.

There may be a time when another professional you are working with will want a copy of your records (lawyer, CPS, medical professionals…). I will write a letter summarizing your treatment record, which will be given directly to you for delivery. Please allow a minimum of 7 days for me to complete this summary.

Your records will be shredded 7 years after our last date of contact, per my licensing rules.

______ **CONFIDENTIALITY**
In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written permission. There are a few exceptions.

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In most legal proceedings, you have the right to prevent your therapist from providing any information about your treatment. In some cases, a judge may order my testimony if he/she determines that the issue demands it. In every situation, I will do all I can to protect your privacy.

By law, a person believing that the mental health or welfare, of a child, elder, or a disabled person, has been or may be adversely affected by abuse or neglect shall immediately make a report (Family Violence Program Provider Manual, subchapter 6451). If a report is necessary, I will make the report with you and keep you involved in the process if I can do so safely.

If I determine that there is a probability of imminent physical injury to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may take reasonable action to inform medical or law enforcement personnel. If I am concerned that you will hurt yourself or someone else, I will take steps to ensure safety. This may include safety planning with you, alerting an emergency contact or getting medical assistance.

______ COMMUNICATION AND SOCIAL MEDIA

We will only communicate in person or over the phone. Emails can be hacked, go to the wrong person, or be printed out of context and be used against you. If you are in an after-hours crisis, please call 911.

Social media is used for personal use only and should not be used in professional relationships. In order to respect the boundaries of both clients and staff, including maintaining confidentiality, there will be no 'friending' or 'following' of each other.

______ INSURANCE – ASSIGNMENT AND RELEASE

I certify that I (and/or my dependents) have insurance coverage with ______________________________________

and that I assign directly to Heather Dunn, MA, LPC-S, LMFT-S all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize Heather Dunn, MA, LPC-S, LMFT-S to release any information necessary to secure payment of benefits. I authorize this signature on all insurance submissions.

______ 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.

______ USE OF TELEHEALTH

There are risks associated with telehealth:

- Sessions completed over video will not have the same feeling as those done in person. Our connection will be different than if we met in person.
- Technical issues may interfere and prevent scheduled sessions from occurring and/or interfere with the quality of the tele-connection.
- The platform we will use is HIPPA compliant, however I cannot guarantee complete privacy or confidentiality. There is always a risk that the system may be hacked by unauthorized people. The platform we use may require downloading applications that provide private and secure services.
- Tele-services are not appropriate for everyone. We will explore other options if this is true for you.

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Expectations for telehealth:

- Both parties will log in at scheduled time for the virtual session. If disconnected, we will both resume video session.
- Scheduled contact will begin and end on time. I will wait up to 10 minutes for your participation. If the session is not initiated within the 10 minute time frame, it will count as "client did not show". You may be charged for a missed appointment.
- You will participate from a private location. If you are not alone, you will let me know immediately. This is so that I don't say anything that might break your confidentiality.

It's important I know where you are if I am concerned about your safety. This is why I ask for your address and an emergency contact. If you are connecting from anywhere but home, let me know. I will only contact your emergency contact if I cannot reach you directly and will only discuss safety concerns.

Emergency contact (name and phone number)

____

Physical address (where do you expect to be during your telesessions?)

____

______ **GRIEVANCE**

If you are concerned about your quality of care, or feel that an ethical violation has occurred, you are encouraged to speak directly with me. If you feel dissatisfied with the outcome you may file a formal complaint against the therapist with:

Texas Behavioral Health Executive Council
333 Guadalupe St, Tower 3, Room 900,
Austin, Texas 78701
(512) 305-7700

The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint. Please call 1-800-821-3205 for more information.

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Upon complete review of all documents in this packet, pages 1-12, your therapist will provide an Acknowledgement and Consent form to be signed by you (the client) and your therapist during the initial session.

I (the client) understand that pages 1-12 (Excluding Signature Pages, pages 4) 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 North 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 form is signed by you (the client) and witnessed prior to the start of counseling services.

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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: _______________________________________ Ins. 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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Notice of Privacy Practices

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

Privacy is a very important concern for all those who come to this office. It is also complicated, because of the many federal and state laws and our professional ethics. Because the rules are so complicated, some parts of this notice are very detailed, and you probably will have to read them several times to understand them. If you have any questions, your therapist will be happy to help you understand our procedures and your rights.

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3. Uses and disclosures that *don't require* your consent or authorization
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    - b. For law enforcement purposes
    - c. For public health activities
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4. Uses and disclosures where you have *an opportunity to object*
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A) Introduction: To our clients

This notice will tell you how we handle your medical information. It tells how we use this information here in this office, how we share it with other professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. If you have any questions or want to know more about anything in this notice, please ask your therapist for more explanations or more details.

B) What we mean by your medical information

Each time you visit us or any doctor's office, hospital, clinic, or other health care provider, information is collected about you and your physical and mental health. It may be information about your past, present, or future health or conditions, or the tests and treatment you got from us or from others, or about payment for health care. The information we collect from you is called **"PHI,"** which stands for **"protected health information."** This information goes into your **medical or health care records** in our office.

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In this office, your PHI is likely to include these kinds of information:

- Your history: Things that happened to you as a child; your school and work experiences; your marriage and other personal history.
- Reasons you came for treatment: Your problems, complaints, symptoms, or needs.
- Diagnoses: These are the medical terms for your problems or symptoms.
- A treatment plan: This is a list of the treatments and other services that we think will best help you.
- Progress notes: Each time you come in, we write down some things about how you are doing, what we notice about you, and what you tell us.
- Records we get from others who treated you or evaluated you.
- Psychological test scores, school records, and other reports.
- Information about medications you took or are taking.
- Legal matters.
- Billing and insurance information

There may also be other kinds of information that go into your health care records here.

We use PHI for many purposes. For example, we may use it:

- To plan your care and treatment.
- To decide how well our treatments are working for you.
- When we talk with other health care professionals who are also treating you, such as your family doctor or the professional who referred you to us.
- To show that you actually received services from us, which we billed to our funders.
- For teaching and training other health care professionals.
- For medical or psychological research.
- For public health officials trying to improve health care in this area of the country.
- To improve the way we do our job by measuring the results of our work.

When you understand what is in your record and what it is used for, you can make better decisions about who, when, and why others should have this information.

Although your health care records in our office are our physical property, the information belongs to you. You can read your records, and if you want a copy we can make one for you. In some very rare situations, you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or believe that something important is missing, you can ask us to amend (add information to) your records, although in some rare situations we don't have to agree to do that.

C) Privacy and the laws about privacy

We are required to tell you about privacy because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires us to keep your PHI private and to give you this notice about our legal duties and our privacy practices. We will obey the rules described in this notice. If we change our privacy practices, they will apply to all of the PHI we keep. We will give you an updated copy when the privacy practices change.

D) How your protected health information can be used and shared

Except in some special circumstances, when we use your PHI in this office or disclose it to others, we share only the **minimum necessary** PHI needed for those other people to do their jobs. The law gives you rights to know about your PHI, to know how it is used, and to have a say in how it is shared. So we will tell you more about what we do with your information.

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Mainly, we will use and disclose your PHI for routine purposes to provide for your care. For other uses, we must tell you about them and ask you to sign a written authorization form. However, the law also says that there are some uses and disclosures that don't need your consent or authorization.

1. Uses and disclosures with your consent

   After you have read this notice, you will be asked to sign a separate consent form to allow us to use and share your PHI. In almost all cases we intend to use your PHI here or share it with other people or organizations to provide treatment to you, arrange for payment for our services, or some other business functions called "health care operations."

   In other words, we need information about you and your condition to provide care to you. You have to agree to let us collect the information, use it, and share it to care for you properly. Therefore, you must sign the consent form before we begin to treat you. If you do not agree and consent we cannot treat you.

   a) The basic uses and disclosure: For treatment, payment, and health care operations

      For treatment. We use your medical information to provide you with psychological treatments or services. These might include individual, family, or group therapy; psychological, educational, or vocational testing; treatment planning; or measuring the benefits of our services.

      We may share your PHI with others who provide treatment to you. If you are being treated by a team, we can share some of your PHI with the team members, so that the services you receive will work best together. The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical record, and so we all can decide what treatments work best for you and make up a treatment plan. We may refer you to other professionals or consultants for services we cannot provide. When we do this, we need to tell them things about you and your conditions. We will get back their findings and opinions, and those will go into your records here. If you receive treatment in the future from other professionals, we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment.

      For payment. We will use your information to bill our funders, so we can be paid for the treatments we provide to you. We will need to tell them about when we met and other similar things.

      For health care operations. Using or disclosing your PHI for health care operations goes beyond our care and your payment. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies, so they can study disorders and treatment and make plans for services that are needed. If we do, your name and personal information will be removed from what we send.

   b) Other uses and disclosures in health care

      Appointment reminders. We may use and disclose your PHI to reschedule or remind you of appointments for treatment or other care. If you want us to call or write to you only at your home or your work, or you prefer some other way to reach you, we usually can arrange that.

      Treatment alternatives. We may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of help to you.

      Other benefits and services. We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

      Research. We may use or share your PHI to do research to improve treatments—for example, comparing two treatments for the same disorder, to see which works better or faster or costs less. In all cases, your name, address, and other personal information will be removed from the information given to researchers. If they need to know who you are, we will discuss the research project with you, and will require you to sign a special authorization form.

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Business associates. We hire other businesses to do some jobs for us. In the law, they are called our "business associates." Examples include a copy service to make copies of your health records, and a billing service to figure out, print, and mail our bills. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy, they have agreed in their contract with us to safeguard your information.

4. Uses and disclosures that require your authorization

   If we want to use your information for any purpose besides those described above, we need your permission on an **authorization form.** We don't expect to need this very often. If you do allow us to use or disclose your PHI, you can cancel that permission in writing at any time. We would then stop using or disclosing your information for that purpose. Of course, we cannot take back any information we have already disclosed or used with your permission.

3. Uses and disclosures that don't require your consent or authorization

   The law lets us use and disclose some of your PHI without your consent or authorization in some cases. Here are some examples of when we might do this.

   a) When required by law:
      - We have to report suspected child abuse.
      - If you are involved in a lawsuit or legal proceeding, and we receive a subpoena, discovery request, or other lawful process, we may have to release some of your PHI. We will only do so after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information they requested.
      - We have to disclose some information to the government agencies that check on us to see that we are obeying the privacy laws.

   b) For law enforcement: we may release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

   c) For public health activities: we may disclose some of your PHI to agencies that investigate diseases or injuries.

   d) Relating to decedents: we may disclose PHI to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.

   e) For specific government functions: we may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment. We may disclose your PHI to workers' compensation and disability programs, to correctional facilities if you are an inmate, or to other government agencies for national security reasons.

   f) To prevent a serious threat to health or safety: if we come to believe that there is a serious threat to your health or safety, or that of another person or the public, we can disclose some of your PHI. We will only do this to persons who can prevent the danger.

4. Uses and disclosures where you have an opportunity to object

   We can share some information about you with your family or close others. We will only share information with those involved in your care and anyone else you choose, such as close friends or clergy. We will ask you which persons you want us to tell, and what information you want us to tell them, about your condition or treatment. You can tell us what you want, and we will honor your wishes as long as it is not against the law.

   If it is an emergency, and so we cannot ask if you disagree, we can share information if we believe that it is what you would have wanted and if we believe it will help you if we do share it. If we do share information, in an emergency, we will tell you as soon as we can. If you don't approve we will stop, as long as it is not against the law.

5. An accounting of disclosures we have made when we disclose your PHI, we may keep some records of whom we sent it to, when we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures.

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E) Your rights concerning your health information

- You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that 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.
- You have the right to ask us to limit what we tell people involved in your care or with payment for your care, such as family members and friends. We don't have to agree to your request, but if we do agree, we will honor it except when it is against the law, or in an emergency, or when the information is necessary to treat you.
- You have the right to look at the health information we have about you, such as your medical and billing records.
- If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to your therapist. You must also tell us the reasons you want to make the changes.
- You have the right to a copy of this notice. If we change this notice, we will give you a new one.
- You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you.

You may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

F) If you have questions or problems

If you need more information or have questions about the privacy practices described above, please speak to your therapist. If you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, contact your therapist or their supervisor. As stated above, you have the right to file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services. We promise that we will not in any way limit your care here or take any actions against you if you complain. If you have any questions or problems about this notice or our health information privacy policies, please contact your therapist, or their supervisor, at 713-472-0753.

The effective date of this notice is 11/1/2017.

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Consent to Use and Disclose Your Health Information

This form is an agreement between you and your therapist. When we use the words "you" and "your" below, this can mean you, your child, or someone else if you have given written permission.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others as discussed in the Consent for Services form, or to help provide other treatment for you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from your therapist.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to your therapist. We will then stop using or sharing your PHI. We may already have used or shared some of it, and we cannot change that.

______________________________________ __________________________

Client Printed Name/Signature Date

______________________________________ ________________________________

Therapist Printed Name/Signature Date

□ Copy of entire consent given to the client (12 pages)

□ Copy denied/refused by client

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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 $75.00** 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. Note: This policy may also apply to sessions provided by Employee Assistance Programs (EAP).

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.

This form MUST be signed BY the Credit Card holder in order for it to be charged for any reason.

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): ____________

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