Shawn D Quintanilla DPC, LPC-S, LMFT
Registered Play Therapist, Certified Trauma Practitioner,
Certified Anger Resolution Therapist, National Certified Counselor
2217 N Park Ave Pearland, Texas 77581
Phone: 281-997-8400 Fax: 281-997-8408
www.shawnquintanilla-lpc.com

This Agreement document contains important information about my professional services and business policies. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time.

My Qualifications

I am a Licensed Professional Counselor-Supervisor and a Licensed Marriage and Family Therapist licensed by the state of Texas with training in working with children, adolescents, adults, families, and groups. I hold a Doctor of Professional Counseling. I am a Registered Play Therapist, a National Certified Counselor, a Certified Trauma Practitioner, and an accredited Certified Anger Resolution Therapist. I am not a medical doctor. I have been in independent private practice since 2012, not a legal partnership. I provide all mental health services through Shawn D Quintanilla DPC, LPC, LMFT, PLLC, d/b/a Wind Rose Counseling.

My practice is limited to children, adolescents, individuals, couples, families, discernment counseling, premarital and marital enhancement counseling. You may bring other family members to a therapy session if you feel it would be helpful or if this is recommended by me. I do not transfer individual counseling to couples counseling. Neither do I see couples individually. I see couples together during the initial interview and then each partner alone but only for one session each, after the initial interview, and only for assessment purposes. Here's the problem I am trying to avoid: I am not immune to persuasion during individual sessions, and whatever is brought up, individually, is not reality-tested by the non-attending person (clearly, not all information divulged in an individual session is raised in the couple's session). It can result in a shift of balance toward the individual that is more believable/most worthy of sympathy, regardless of therapist training. I am not an advocate of individual sessions for couples, despite some benefits. I think the process is much cleaner if all sessions are with both individuals present and everything is heard by everyone at the same time. Referrals will be provided to individuals desiring a transfer to couples.

Services

Counseling results vary depending on the personalities of the counselor and client, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems you hope to address. Success in counseling calls for a very active effort on your part. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. In order for your goals to be most successfully achieved, you will have to work to resolve your own problems with my assistance both during our sessions and at home. The number of sessions needed depends on many factors and will be discussed by the therapist.

Counseling sessions have both benefits and risks. You may learn things about yourself you do not like. Often growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. While it may not be easy to seek help from a mental health professional, there are also many benefits to being involved in counseling. It often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. It is hoped that you will be better able to understand your situation and feelings and move toward resolving your difficulties. I will use my knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. However, there are no guarantees of what you will experience. The success of our work together depends on the quality of effort on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy.

It is also important that you remember that although our sessions may be very intimate emotionally and psychologically, that we have a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that I do not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Our contact will be limited to the paid sessions you have with me.

A tool I frequently use in therapy is called sandtray. Sandtray Therapy prompts you, as the client, to use as few or as many objects as needed to create a symbolic "world" in the sand. This allows for therapy to occur in a way that feels safe because the client takes the lead in making meaning, but it also allows for therapy to go more deeply into places where we may not always have words to describe our experiences.

Because sandtray is a visual medium, I will take photos of completed scenes that will be part of the counseling file. If you are uncomfortable with this, let me know. If you have discomfort in touching sand, let me know and I can accommodate to meet your needs. You can always ask questions or advocate for yourself in any part of our work together.

At times it may become necessary to use video-conferenced therapy ("telehealth"). In order to do so, you must be a resident of Texas. 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, employees, or designees from any liability in connection with your participation in the telehealth sessions.

Telehealth sessions may be recorded and stored electronically as part of your medical records. Sessions, test results, and disclosures will be held in confidence subject to state and/or federal law.

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.

Meetings

Our first few sessions will involve an evaluation of your goals. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a plan to follow to achieve your goals if you decide to continue in counseling. I will usually schedule one session per week at an agreed upon time. Appointments are made by calling 281-997-8400 Monday through Friday, times vary.

Please leave your phone in the car or make sure it is silenced or turned off during the session. This does not include placing it on vibration. This is still distracting to the session. Our sessions are a place where you can unplug from your technological life and plug into your emotional one.

Fees

Fees for services are based on time approved session length determined by insurance carrier. Self-pay session are $125 for each 50 minute session. Upon your request, an income based sliding scale is used to determine session fees for individuals, couples, and families not using a health insurance policy. In addition to weekly appointments, I charge $25 for each 15 minute increment 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.

Please let the office know if you need to cancel a scheduled appointment by 1:00 pm the day prior to your appointment. In the event you do not show up for an appointment nor give appropriate notice, a $75.00 fee will be charged for the missed appointment. In the event there are three sessions cancelled late or not shown up to, all future sessions will be cancelled and referrals will be provided. The no show or late cancellation fee must be paid before the next scheduled session. This fee is not covered nor reimbursed by insurance. You are responsible for calling to cancel or reschedule your appointment regardless if you receive a reminder call or not.

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 representation's fees. I charge $400.00 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 $1,600 for half a day: 8:00AM – 12:00PM or $3,200 for an entire day. After six months, fees may increase. This fee is not covered by insurance.

Payment is expected for 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.

For a copy of clinical records, there is an administrative fee of $25.00 for the first twenty pages and 50¢ for each page thereafter along with a reasonable fee for the cost of mailing, shipping, or delivery.

Insurance Reimbursement

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. My office will fill out forms and provide you with whatever assistance in helping you receive the benefits to which you are entitled; however, you are responsible for the full payment of my fees. It is very important that you know exactly what mental health services your insurance policy covers. If you have any questions about the coverage, call your plan administrator.

Also be aware that it may be required that I provide your insurance company with a diagnostic code and information relevant to the services that I provide to you, sessions, or processing of insurance claims, including but not limited to your name, social security number, birthdate, and clinical or medical record information. I will make every effort to release the minimum information about you that is necessary for their purposes.

Contacting Me

Due to my schedule, I am often not immediately available by telephone. Although I am usually in the office, I will not answer the phone when I am with a client. Administrative staff are available Monday through Friday, times vary. Messages may be left 24 hours a day, seven days a week. A confidential message may be left at my extension – 102. Phone calls will be returned as promptly as possible by the end of the work day, Tuesday through Saturday. If you are difficult to reach, please inform me of times when you will be available. Extended phone calls will be scheduled and billed according to standard fee.

If you are unable to reach me and feel you cannot wait for me to return the call, contact your family physician. If it is an emergency then call 211, 911, or go to the nearest emergency room and ask for the mental health professional on call. If I am going to be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary.

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.

You are ordinarily guaranteed access to your, or your child's, medical records and that copies of medical records are available to you through written request. However, based on my professional judgement, if providing your records could threaten the safety of yourself or another human being, the request may rightfully be declined.

If such a request is made and honored, you retain sole responsibility for the confidentiality of the records released to you.

Limits of Confidentiality

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:

- Consultation with other health and mental health professionals about your case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information discussed confidential. I will tell you about these consultations if I feel it is important to our work together. I will also note all consultations in your record.
- 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 _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

- While my present or potential clients might conduct online searches about my practice and/or me, I do not search my clients on Google, YouTube, Facebook, other search engines or online social networking sites. If clients ask me to conduct such searches or review their web sites or profiles and I consider that it may be helpful, I will consider it.
- 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.

Transfer Plan for Incapacitation or Death

In the unlikely event that I am unable to provide ongoing services Gale Grant, LPC will take possession of my files and records. Gale Grant, LPC may be contacted at 281-997-8400. Her role as custodian includes:

- I will provide her location(s), keys, passwords, access codes and other information necessary or a protocol to obtain this information in order to execute the transfer plan.
- She will send a letter to you notifying you of my inability to practice. She will provide referrals to the most appropriate service provider.
- She will take possession/responsibility of the clinical records and inform you on procedures to access your clinical records.
- She will respond to a request for information in concert with state laws, HIPAA guidelines and code of ethics.
- She will maintain clinical records (post treatment) for adults 6 years or 5 years past age of majority for minors.

By signing this information and consent form, you voluntarily give your consent to allowing Gale Grant LPC to take possession of your file and records and provide you or a therapist of my choice with copies upon request in the event I die or become incapacitated.

By signing this form you affirm that prior to becoming a client you were given sufficient information to understand the nature of counseling and you have had all your questions answered fully. You agree to play an active role in this process. You further understand that no guarantees have been made to you as to the results of the counseling process. You understand that at times a photographic record will be kept of interventions, and that these photographs will become part of the permanent client record, following all applicable legal and ethical rules of confidentiality.

You should consider this information along with your own opinions of whether you feel comfortable working with me because counseling involves a commitment of time, money and energy. Feel free to discuss any questions you have about my procedures whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Complaint Process

An individual who wishes to file a complaint against a Licensed Professional Counselor or Licensed Marriage and Family Therapist may write to:

Texas Behavioral Health Executive Council
333 Guadalupe St., Ste 3-900
Austin, Texas 78701
1-800-821-3205

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Upon complete review of all documents in this packet, pages 1-17, 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 1-17 (Excluding Signature Pages, pages 6 and 7) 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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Upon complete review of all documents in this packet, pages 1-17, your child's therapist will provide a Minors and Parents form to be signed by you (the legal guardian) and your child's therapist during the initial session.

I (the legal guardian) understand that pages 1-17 (Excluding Signature Pages, pages 6 and 7) 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 legal guardian) understand that my signature is required on the Minors and Parents form before services can be provided. I (the legal guardian) understand that if **I choose NOT to sign the Minors and Parents form counseling services will NOT be provided.**

IMPORTANT: It is required the Minors and Parents form is signed by you (the legal guardian) and witnessed prior to the start of counseling services.

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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Your Information. Your Rights. Our Responsibilities.

This notice describes how personal mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper mental health record
- Correct your paper mental health record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Market our services

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Bill for your services
- Help with public health and safety issues
- Comply with the law
- Work with a medical examiner or funeral director
- Address worker' compensation, law enforcement, and other government requests
- Respond to lawsuit and legal actions

Your Rights

When it comes to your mental health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a paper copy of your medical record

- You can ask to see or get a paper copy of your mental health record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your mental health information, usually within 15 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct mental health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain mental health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your mental health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your mental health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

We will not retaliate against you for filing a complaint.

Your Choices

For certain mental health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your mental health information?

We typically use or share your mental health information in the following ways:

- **Treat you**
  We can use your mental health information and share it with other professionals who are treating you.
  Example: A therapist seeing you for therapy consults with a psychiatrist about your overall condition.
- **Run our organization**
  We can use and share your mental health information to run our practice, improve your care, and contact you when necessary.
  Example: We use mental health information about you to manage your treatment and services.
- **Bill for your services**
  We can use and share your mental health information to bill and get payment from health plans or other entities.
  Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your mental health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share mental health information about you for certain situations such as:

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for mental health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests

We can use or share mental health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share mental health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in the office, and on the web site.

Other Instructions for Notice

Effective Date of this Notice: *November 30, 2017*

- Privacy official: Shawn D Quintanilla, 832-303-3992 or squintanilla.lpc@gmail.com
- We never market or sell personal information.
- We will never share any substance abuse treatment records without your written permission.
- This notice applies to Shawn D Quintanilla DPC, LPC-S, LMFT, CART, CTP, NCC, Registered Play Therapist

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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: _____

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 Shawn D Quintanilla DPC, LPC-S, LMFT all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize Shawn D Quintanilla DPC, LPC-S, LMFT 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.

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

Print Name: _____

Signature: _____ Date: _____

MINORS:

Parent's Printed Names_____

Parent's Signatures_____ Date_____

Parent's Printed Names_____

Parent's Signatures_____ Date_____

Email and Telehealth 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. Technology is a very convenient way to handle administrative issues like scheduling or receipt requests, but technology is not 100% secure. Some of the potential risks you might encounter include:

- Email passes through many unsecured servers before arriving at final, intended destination. Such companies may lack security protocols of a wide variety of areas, from the handling of data to the hiring of employees. For instance, some servers have practices that leave email vulnerable to scrutiny by minimally trained or employees without any security clearances.
- Email can automatically generate unsolicited and unwanted advertisements within email programs for products related to potentially problematic topics being discussed, such as contraceptives, visiting a specific geographic area, purchasing a car or any other topic that could lead to complications if found by someone other than the intended recipient.
- Email can be lost and otherwise simply fail to be delivered.
- Email may be sent to the wrong address by malfunctioning hardware or software.
- Email delivery can be delayed.

Of course, other problems can arise with email that are not related to the technology per se, but rather, human errors or intentional deception. Such factors could include:

- As mentioned above, unintended recipients can open and read email, even if it is delivered to the right address.
- Sensitive information could be emailed to the wrong address.
- Email can accidentally be sent to an unintended group.
- Email can be sent prematurely, before the author intended to release it.
- The sender of an email could forget to remove previously exchanged emails that have been carried from previous exchanges in the same thread. This information can be damaging for a wide variety of reasons.

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 technology 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 technology below and sign. **(CIRCLE ONE OF THE OPTIONS BELOW)**

I **DO** or **DO NOT** consent to use of technology.

If given, please provide email address legibly: _____.

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 contact the office.

Printed 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 $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.

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): _____

Shawn D Quintanilla DPC, LPC-S, LMFT
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Certified Anger Resolution Therapist, National Certified Counselor
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Phone: 281-997-8400 Fax: 281-997-8408
www.shawnquintanilla-lpc.com

I, _____, am aware in the event I do not show up for an appointment nor give appropriate notice by 1:00 pm the day prior to the missed appointment, a $75.00 fee will be charged for the missed appointment.

Furthermore, I am aware in the event if there are three sessions cancelled late or not shown up to, all future sessions may be cancelled. The no show or late cancellation fee must be paid before the next scheduled session. This fee is not covered by insurance.

Emergencies do occasionally occur. This $75 fee for missed appointments may be waived in the event of an emergency. However, **this waiver only allows 3 emergency situations**.

I understand regardless of the reason for the missed appointment after the 3 waived emergency situations, I will be responsible for the $75 fee for any future appointments I do not show up for nor give appropriate notice by 1:00 pm the day prior to the missed appointment.

Acknowledgment of Emergency Waiver Policy

_____ _____ _____

Client printed name Signature Date

_____ _____

Shawn D Quintanilla DPC, LPC, LMFT Date

Dates waiver utilized:

Reason and Date Missed Signature and Date of Acknowledgement

_____

_____

_____

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Animal-Assisted Therapy (AAT)

Therapy focuses on developing ways to address your particular concerns about your life. Sometimes animals can aid therapy by helping us feel safe, loved, and accepted. It is widely known that animals can help alleviate stress, depression, anxiety, and promote health and well-being. Sometimes animals sense things that may be out of our awareness, and they react by attempting to connect with us, perhaps by putting their head on your lap or gently nudging you with their nose. This can be an animal's way of saying they know, understand, and want to help you. Animals can also help with developing social skills or self-care skills. Occasionally, when an animal does something, such as act scared, a person may identify with that feelings, and that becomes an opportunity to discuss what is happening for the client.

Animal-Assisted Therapy may be beneficial for issues such as:

- Bullying
- Adjust to major life changes
- Grief and loss
- Problems at school
- Physical or sexual abuse
- Crisis and trauma
- Behavioral and emotional challenges
- Anxiety
- Difficulty making or keeping friends
- Coping with a disability
- Negative or dangerous behavior
- Effects of divorce and abandonment
- Depression
- Attention deficit/hyperactivity (ADHD)
- Disruptive behavior
- Obsessive compulsive disorder

BRISCO, MY SHIH TZU, OR DANNY, MY POODLE MIX, WILL BE JOINING ME TO HELP FACILITATE THE HEALING PROCESS.

I have decided to participate, or allow my minor child to participate, in Animal-Assisted Therapy (AAT) with Shawn Quintanilla. By signing, I certify I understand that I have been informed and understand that there is always some unavoidable risk of injury involved when working with animals. I acknowledge that dogs can be inherently difficult to control and that even well trained dogs will not be under control at all times resulting in the possibility of injury. Additionally, by signing, I acknowledge I have had full opportunity to discuss all concerns I have about the foregoing risks. I have also made all inquiries and investigations to my satisfaction related to such risks.

I hereby accept and assume, without reservation, all risks associated with my participation, or my minor child's participation, in AAT. I waive, release, discharge, and agree not to sue and to indemnify, defend and hold harmless Shawn D Quintanilla LPC from any and all injuries, including costs associated therewith, including attorney fees, court costs, and consultant fees arising from my participation in AAT.

This waiver shall be legally binding on the releasing party/parties.

Client's printed Name: _____

Signature: _____ Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Concerns:

Please **mark any items below that apply** and **add any others at the bottom** under "Any other concerns or issues".

- ❑ Abuse—physical, sexual, emotional, neglect
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Custody of children
- ❑ Childhood issues (your own childhood)
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription, OTC medications, street drugs
- ❑ Eating problems—overeating, under eating, purging, etc.
- ❑ Fatigue, tiredness, low energy
- ❑ Financial or money troubles
- ❑ Fertility Issues- miscarriages, difficulty conceiving, etc.
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Health, illness, medical concerns, physical problems
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Loneliness
- ❑ Legal matters, charges, suits
- ❑ Marital conflict, distance, infidelity/affairs
- ❑ Mood swings
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (repetitive thoughts or actions)
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, relatives, or coworkers)
- ❑ Remarriage
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress
- ❑ Suspiciousness, distrust
- ❑ Suicidal thoughts
- ❑ Temper problems
- ❑ Threats, violence
- ❑ Withdrawing or isolating from others
- ❑ Work problem
- ❑ I have no problem or concern bringing me here

Other concerns or issues: _____

_____

_____

Check any of the following that describe you:

- ❑ I am unable to do the things I used to do.
- ❑ I get tired for no reason.
- ❑ I think about killing myself.
- ❑ I am gaining/losing weight.
- ❑ I feel hopeless about the future.
- ❑ I feel sluggish/restless.
- ❑ I feel unhappy.
- ❑ I can't make decisions.
- ❑ I am sleeping too little (or too much).

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. _____

Please describe in more detail the main difficulty that has lead you to seek therapy: _____

_____

_____

Who can I thank for referring you to me? _____