**OAKWOOD COUNSELING CENTER**

**176 S. Hickory Ave.**
**New Braunfels, Texas 78130**
**Office 830-627-7006 Fax 830-627-7007**

# CLIENT'S RIGHTS

1. You have the right to decide not to receive counseling from me.

2. You have the right to end counseling at any time without any additional moral, legal, or financial obligations.

3. You have the right to ask any questions about the procedures used during counseling. If you wish, I will explain all therapeutic procedures and their rational to you.

4. You have the right to review your records. This right may be limited if it is thought to be harmful to your mental health.

5. You have the right to prevent electronic recording of any part of the counseling session.

6. You have the right to confidentiality. Information revealed by you during counseling will be kept strictly confidential and will not be revealed to any other person or agency without your written permission, except as described below.

7. With a written request from you, any part of your record can be released to any designated person or agency. I will tell you if I think that making your record public could be harmful to you.

8. There are certain situations in which, as a counselor, I am required by law to reveal information obtained during counseling sessions, even if you do not give permission. These situations are as follows:

   a. If you threaten grave bodily harm or death to yourself or another person, I am authorized by law to inform the appropriate law enforcement agencies.
   b. If you report to me your knowledge of physical or sexual abuse of a minor child or an elderly person, I am required by law to inform the appropriate agency so they can investigate the matter.

9. You have the right to address complaints against me, or any other Licensed Professional Counselors or Licensed Marriage and Family Therapists, to the following boards:

Texas State Board of Examiners of Professional Counselors
1100 West 49th Street
Austin, Texas 78756-3183.
512-942-5540.

Texas State Board of Marriage and Family Therapists
1101 West 49th Street
Austin, Texas 78756-3183
512-834-6657.

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# CLIENT INFORMATION – ADULT

**PLEASE PRINT CLEARLY** DATE_______________________

NAME__________________________________DOB________AGE______SEX____

ADDRESS__________________________________________________________

CITY & STATE____________________________________ZIP__________________

[ ] SINGLE [ ] MARRIED [ ] SEPARATED [ ] WIDOWED [ ] DIVORCED

HOME PHONE___________BUSINESS PHONE__________CELL PHONE___________

EMAIL ______________________________________________________________

OCCUPATION________________________________________________________

SPOUSE'S NAME______________________________________________________

HOME PHONE___________BUSINESS PHONE__________CELL PHONE ___________

OCCUPATION________________________________________________________

REFERRED BY________________________________PHONE__________________

My therapist, ______________________________________has my permission to contact ____________________ _______________ to thank him/her for referring me to the Oakwood Baptist Counseling Center.

CLIENT'S SIGNATURE ___________________________________________________

ADDRESS__________________________________________________________

EMERGENCY CONTACT PERSON_____________________________________________

PHONE_________________________RELATIONSHIP________________________

I give permission for my counselor/therapist to call ______________________________in an emergency situation.

**My therapist has permission to make a phone call and leave messages that include a name, the church name, and a return phone number.**

Client's Signature_____________________________Date______________________

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# AUTHORIZATION FOR RELEASE OF INFORMATION
## ORAL

I, ___________________________, authorize my counselor, Dorothy Jones, LPC, to release information during the course of my counseling to the following persons and/or organizations.

Information regarding my treatment plan and my psychological, emotional, and spiritual needs and issues may be discussed with the following people. The purpose is to gain their perspective, understanding, and support, and if needed, to invite them to participate in counseling sessions.

### RELEASE INFORMATION TO, OR OBTAIN INFORMATION FROM:

**Please leave line blank if you do not want us to contact someone.**
**Initial next to the "yes" for those persons we may contact.**

___Yes Spouse_____________________________________ Ph____________________

___Yes Family Member_______________________________ Ph____________________

___Yes Parent/Guardian______________________________ Ph____________________

___Yes Significant Other______________________________ Ph____________________

___Yes Significant Other______________________________ Ph____________________

**Information regarding my treatment plan, psychological needs, issues, progress, follow-up needs, and suspected medical needs may be discussed with the following individuals or organizations. The purpose is to obtain and provide information relevant to current and future treatment needs.**

___Yes Physician____________________________Ph_____________________________

___Yes Counselor____________________________Ph____________________________

**Information including my name, general situation, and needs may be discussed with the following for the purpose of obtaining support, insight and prayer.**

___Yes Pastor_______________________________Ph____________________________

- My judgment is neither impaired by emotional duress nor chemicals.
- I realize that I may withdraw this authorization in writing at any time.
- If not withdrawn, this authorization expires at the conclusion of the counseling relationship.

Date____________________ Signature__________________________________________

OAKWOOD COUNSELING CENTER
176 S. Hickory Avenue
New Braunfels, TX 78130
830-627-7006

# INFORMED CONSENT CONTRACT

This agreement for counseling services between Dorothy Jones, a Licensed Professional Counselor (LPC), at Oakwood Counseling Center, and ________________________________ (client) shall govern all professional relationships between the parties.

______ **THE COUNSELOR**
INITIAL

Your counselor is Dorothy Jones. She is a Licensed Professional Counselor (LPC) and holds a Master of Arts Degree in Professional Counseling. Her relationship with a client will be on a professional basis only. The LPC Code of Ethics strictly forbids a counselor to form a relationship with a client outside the counseling parameter.

______ **CONFIDENTIALITY POLICY**
INITIAL

All therapeutic communications, records, and contracts with your counselor will be held in strict confidence. Information may be released in accordance with state law, only when:

1. The client signs a written release of information that indicates informed consent to such release.
2. The client elects to use insurance, managed care organizations, or other third-party payers. Regretfully, we cannot maintain desired confidence when the client elects to use insurance or other third-party payers. Confidentiality is not respected in most cases of managed mental health care. Clients who choose to use insurance and managed care programs, agree that they will hold the staff harmless for any and all disclosures of confidential records and information demanded by and released to third-party payers, and consequences of such.
3. The client expresses serious intent to harm himself/herself or someone else.
4. There is evidence or reasonable suspicion of abuse against a minor child, an elder person 65 years or older, or a dependent adult.
5. A subpoena or other court order is received directing the disclosure of information. It is policy to assert either "privileged communication," in the event of a subpoena or court order, and the right to "consult the client" prior to any mandated/requested disclosure.
6. You have been referred to counseling at this facility by the court. You can assume that the court wishes to receive some type of report or evaluation. You should discuss with your counselor exactly what information may be included in a report to the court before you disclose any confidential material. In such instances, you have the right to tell the counselor only what you want him or her to know.
7. You are involved in litigation of any kind, and inform the court of any counseling services received. You are making your mental health an issue before the court and you may be waiving your right to keep your records confidential.

8. Electronic Communications: We cannot ensure the confidentiality of any form of communication through electronic media, including text messages. You are also advised that any email sent via computer in a work-place environment is legally accessible by an employer. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, we will do so. Response to scheduling or cancellation messages will be made during normal business hours, Monday through Thursday. We request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

   I am ethically and legally obligated to maintain records of each time we meet, talk on the phone, or correspond via electronic communication such as email or text messaging. These records include a brief synopsis of the conversation along with any observations of plans for the next meeting. A judge can subpoena your records for a variety of reasons, and if this happens, I must comply.

Children eighteen years of age are considered legal adults when involved in mental health services. Confidentiality, in these situations, is restricted by the same laws that apply to adults. Before the age of eighteen, communication of confidential information between counselor, client, and parents or legal guardians is at the discretion of the counselor.

In addition, the therapists on the Oakwood counseling team may discuss my case for the purpose of professional consultation. All therapists are governed by the same laws of confidentiality.

Confidential files will remain with the counselor 5 years after the last counseling visit. In event of the counselor's death, illness, retirement, or relocation the counseling center will have information to help you access your records. It is the counselor's responsibility to advise the counseling center of their whereabouts.

Clients with any concerns or questions about this policy agree to address them with their counselor at the earliest possible time, in order to resolve them in the client's best interest.

_______ **CANCELLATION POLICY**

INITIAL

Clients are asked to be punctual to all appointments. An appointment canceled after 5:00pm the day before the appointment, or an appointment that is missed without justification, will be charged to the client.

If a counselor double-books an appointment, fails to cancel in a timely manner, or fails to show at the appointed time without justification, the next appointment will be free of charge.

______ **WORK AGREEMENT**
INITIAL

The first few sessions are a time of mutual evaluation. A joint determination will be made as to whether the counseling seems comfortable and appropriate. If at any time, and for any reason, the relationship does not seem workable, other options will be discussed. The client may seek other options on his or her own, or the counselor may present other options for consideration. These options may include referral to another counselor or to a specialist for consultation or testing.

The client agrees to inform the counselor of any conflict, disagreement, or hurt feelings pursuant to the counselor, that may arise, before such things become a major hindrance in the counseling relationship, and thus affect the desired counseling outcome.

The following conditions will be assessed for possible suspension, termination or referral of the client:

1. A pattern of missed appointments
2. A pattern of skipped homework assignments
3. Attending counseling sessions while under the influence of alcohol or drugs

The benefits of counseling can be tremendous; however, it is not possible to guarantee desired results. The client is expected to prioritize his or her healing, by consistently taking responsibility for doing his or her part in a timely manner.

_______ **CONTACTING THE COUNSELOR**
INITIAL

Calls placed to the counselor's office should be for brief consultation, (no longer than 15 minutes), or for an emergency situation. Should a long consultation be needed, the client should schedule an additional appointment.

**An emergency constitutes a situation in which someone is:**

1. Out of control
2. Has plans of self-harm or of harming others
3. Demonstrates potentially harmful behavior

**IN AN EMERGENCY,**
**PLEASE CALL THE COUNSELOR IMMEDIATELY**

To whomever answers the phone, state that the call is an emergency, and the counselor will be interrupted to take your call.

**The counselor will attempt to return emergency calls immediately, 24 hours a day.**

Should there be an unforeseen delay in returning an emergency call, please dial 911, or go to the nearest hospital emergency room.

**Office:** **830-627-7006**

______ **COUNSELING TECHNIQUES**
INITIAL

The primary therapy used during sessions will be Cognitive-Behavior Therapy (CBT). CBT is based on theoretical rationale that the way people feel and behave is determined by how they perceive and construct their experience. The aim is to help clients replace faulty thought patterns and behaviors with healthy thoughts and actions. In addition to this theoretical aspect, God's word will be utilized as a reference. Homework, scripture and prayer may be incorporated into the sessions based on client need and preference.

______ **FEES FOR SERVICE**
INITIAL

Insurance generally does not cover counseling done at this facility. The fees are low enough, in many cases, to be equal to an insurance co-payment. Should insurance cover counseling appointments, the counselor will comply with any requests for information from the insurance company. It is the client's responsibility to file all forms and to collect reimbursement from the insurance company. Payment to the counselor is due at the time of service. Receipts can be requested at the end of each session, and contain all of the information needed to obtain insurance reimbursement, provided the client's policy allows coverage.

The fee is $75.00 for an individual session and $85.00 for any marital or family sessions. The fee for Group Therapy is $30.00 per session. Payment is due at the time of service. Should a client's bill reflect that it has become two payments in arrears; the client will make payment prior to attending the next scheduled session.

Financial assistance is sometimes made available at a client's home church. Should you need financial assistance, the administrative assistant or the counselor will provide a Home Church Financial Assistance Application that may be completed and presented to the appropriate person at your church. If a client is receiving Home Church Assistance, and he or she does not show up for an appointment or fails to cancel in a timely manner, he or she will be responsible for the full fee of the missed session.

Counselors at Oakwood Counseling Center do not routinely write letters for clients. If a letter is required, a fee of $40.00 will be charged. The fee is due at the time of the request.

_______ **COURT FEES AND COURT APPEARANCES**
INITIAL

For those clients involved in the legal system (i.e., court ordered counseling of custody situations), it is your responsibility to inform Dorothy Jones, LPC.

If a client requires Dorothy Jones to be involved in legal matters, he or she will be responsible for the additional fees outlined below. Please keep in mind that Dorothy Jones's testimony may not be solely in your favor or best interest. Dorothy Jones can *only* testify to the facts.

Dorothy Jones is **not** a court appointed evaluator for child custody and **cannot** determine the living arrangements of your child(ren). Parents should be mindful that the effectiveness of counseling is based on trust, honesty, and willingness to be open in a safe place. Involving the legal system in counseling interferes with the treatment process and can pose significant psychological risks. Therefore, clients are *strongly* discouraged from having Dorothy Jones release confidential information about the counseling session or testify on their behalf.

- Preparation time (including submission of records): $110/hour
- Time away from office including Depositions or Testimony: $250/hour
- All attorney fees and costs incurred by the therapist as a result of the legal action.
- Filing a document with the court: $100
- Mileage: current standard rate
- The minimum charge for a court appearance: $1500

A retainer of $1500 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48 hours notice there will be an additional $250 "express" charge. Also, if the case is reset with less than 72 business hours notice, then the client will be charged $500 (in addition to the retainer of $1500).

_______ **COMPLAINTS**
INITIAL

Reports of suspected unethical or illegal acts on the part of the counselor may be reported to the state board that issued the therapist's license or licenses, i.e. LPC, LMFT. The following numbers are also posted on the wall of Oakwood Counseling Center, and they are printed at the bottom of the Client's Rights:

Texas State Board of Examiners of Professional Counselors
1100 West 49th Street
Austin, Texas 78756-3185
512-942-5540

Texas State Board of Marriage and Family Therapists
1100 West 49th Street
Austin, Texas 78756-3185
512-834-6657

**SERVICE AGREEMENT**

We, the undersigned counselor and client, have read and fully understand this agreement and the stated policies. We agree to honor these policies and will respect one another's views and differences. Finally, we agree that any disputes or modifications of this agreement shall be negotiated directly between us.

Client Signature: ________________________________________ Date:____________

Counselor
Signature: _______________________________________________ Date:____________

**CONSENT FOR TREATMENT OF A MINOR CHILD**

I certify that I am the (father, mother, managing conservator, legal guardian) of _______________________, and I give my authorization and informed consent for him or her to receive assessment and out-patient counseling from Dorothy Jones, LPC, at Oakwood Counseling Center. I certify that I have the legal authority to authorize and consent to this treatment.

Legally Authorized Signature:

______________________________________________________ Date:____________

Printed Name ______________________________________________ ____________

Address ___________________________________________________ ____________

This agreement will expire at the termination of the counseling relationship, or with a written request for termination.

# Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

**I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
    - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
    - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care options are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

**II. Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1)I have relied on that authorization; or (2)if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

**III. Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse**: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse**: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.

- **Health Oversight**: If a complaint is filed against me with the Texas State Board of Examiners of Psychologists, they have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety**: If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation**: If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

**IV. Patient's Rights and Psychologist's Duties**

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a revised notice either at the office or through the mail.

**V. Questions and Complaints**

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Dorothy Jones, LPC, 210-884-7376. If you believe that your privacy rights have been violated and wish to file a complaint with *me/my office,* you may send your written complaint to or call Dorothy Jones, LPC, 210-884-7376. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

**VI. Effective Date, Restrictions and Changes to Privacy Policy**

This notice will go into effect on July 1, 2012. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by either mail or at the office.

Your Counselor
Dorothy Jones, LPC

Oakwood Counseling Center
176 South Hickory Ave.
New Braunfels, TX 78132
830-627-7006 office
830-627-7007 fax

**Acknowledgement Form**

Your signature below indicates that you have read the Client Services Agreement and agree to its terms, and also serves as an acknowledgement that you have received the HIPPA Notice Form.

Furthermore, your signature indicates that you understand the cancellation policy and that you agree to pay the full fee of the missed session should you not show to a scheduled session or fail to provide 24 hours advance notice of cancellation.

__________________________________ _______________
Client/Guardian Signature Date

__________________________________ _______________
Client/Guardian Signature Date

__________________________________ _______________
Therapist Signature Date