CY-HOPE COUNSELING
The Center for Children and Families

12715 Telge Rd.
Cypress, TX 77429
713.466.1360
www.cy-hopecounseling.org

Qualifications

I am pleased you have selected me as your counselor. This document is designed to inform you about my background and to ensure that you understand our professional relationship. I earned my Bachelor's degree in Psychology from Grand Canyon University and my Master's degree in Professional Counseling from Grand Canyon University with an emphasis in marriage and family therapy. My current role at Cy-Hope Counseling is a Licensed Professional Counselor Associate working toward becoming a Licensed Professional Counselor. I am currently being supervised on site by our Clinical Director, Courtney Suddath, M.A., LSSP, LPC-S, Licensed Professional Counselor Supervisor. There may be times that my supervisor will join in our sessions as an observer. Additionally, there may be times that portions of the session are video recorded for training purposes only.

Nature of Counseling

The people I accept into counseling with me are those fully capable of resolving their own issues and concerns. The amount of sessions taken to resolve these issues could be few or many. If counseling is effective, you should be able to face the challenges of life on your own without my intervention.

Although our sessions may be very intimate emotionally and psychologically, it is important for you to realize that we have a professional relationship rather than a personal one. Our contact is limited to the scheduled sessions you have with me. Therefore, I will not be able to attend social gatherings with you, accept gifts from you, or have any relationship, other than a professional one, with you. You will learn a great deal about me as we work together during your counseling experience. However, it is important for you to remember that you are experiencing me only in my professional role.

Referrals

If you become dissatisfied with my services at any time, please let me know. It is my obligation to provide a list of other professionals that may be of more help to you.

Center Policies

It is The Center's policy that any child age 12 and younger have a parent or adult guardian remain onsite for the entire counseling session.

If a client cancels and/or does not show to 3 consecutive appointments, The Center reserves the right to change the client's counselor and/or appointment time.

Records and Confidentiality

The law protects the privacy of all information obtained during the counseling process. In most situations, the Center can only release information about a client if the client, a parent, or guardian signs a written Release of Information. A Release of Information is specific to an individual, another professional, school or agency. You should also be aware that, pursuant to Texas law, any test data can only be released to trained mental health professionals.

There are some situations where the Center is permitted or required to disclose information without either a consent or a Release of Information. These include:

1. If a client is involved in a court proceeding and a request is made for information concerning the client. The Center cannot provide any information without the client's or client's legal representative's written authorization. However, if the Center receives a court order, the Center may disclose information without the client's consent or authorization. If the client is involved in or contemplating litigation, the client should consult his/her attorney to determine whether a court would likely order the Center to disclose information.
2. If the client's records are subpoenaed as part of a criminal investigation, the Center must disclose the client's records without the client's consent or authorization.
3. If a client files a complaint or lawsuit against the Center, the Center may disclose relevant information regarding the client without the client's consent or authorization in order to defend itself.

There are some situations in which the Center is legally obligated to take action. These include:

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1. If the Center has cause to believe a child under age 18 has been or is at risk to be abused or neglected (e.g. physical injury, a 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 the Center to make a report to the appropriate governmental agency. This is usually the Texas Department of Family and Protective Services. Once such a report is filed, the Center may be required to provide additional information to this agency.
2. If during the course of counseling the Center learns that a client has been sexually abused or exploited by a mental health professional, state law requires the Center to report this information to law enforcement and the professional's licensing board.
3. If the Center determines that there is a probability that the client is in imminent danger of harming himself/herself or others, the Center may contact family members or others (e.g. medical, mental health, or law enforcement personnel) to provide protection for the threatened individuals.

I will keep a written record of our own sessions. Some sessions may be audio and/or video-taped. This is for the protection of both parties involved and will be kept confidential. It is my intention to render my services in a professional manner consistent with the accepted standards of practice. Please note that after 30 days without contact between us, Cy-Hope Counseling will no longer consider you a client. Should you wish to return for services, you will begin the intake process again.

Individual counseling sessions typically run 45 – 50 minutes. Play therapy sessions generally are 30 – 45 minutes. Your consideration in arriving **on time for your scheduled appointment is greatly appreciated**. In the event of a cancellation, **24 hours prior notice is necessary** to avoid being charged for the session. Fees for various counseling services are noted on the attached *Fee Schedule*. Payment is due at the time service is provided.

NOTICE TO CLIENTS
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.

May we acknowledge by correspondence the person or agency whom referred you? **Yes** **No**

Who may we thank for referring you to Cy-Hope Counseling?

_____

Please sign and date this form showing that you agreed to the aforementioned terms.

_____ _____

Client/Parent/Guardian Signature Date Therapist Signature Date

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Patient Information Record

Patient Name (first, middle, last): _____

Date of Birth: _____ /_____ /_____ Sex: Male Female Age: _____

Race:_____ Ethnicity:_____ Language Preferred:_____

Grade, if applicable:_____ School, if applicable: _____

Street Address: _____City: _____St: _____ Zip: _____

Primary Phone: _____ Cell Phone: _____ Texting OK? Yes No

Email: _____

(if patient is a minor, please fill in parent information for below)

Parent Name

_____

Address: _____

_____
City State Zip

Email: _____

Primary Phone: _____

Cell Phone: _____

Texting OK? Yes No

Parent Name

_____

Address: _____

_____
City State Zip

Email: _____

Primary Phone: _____

Cell Phone: _____

Texting OK? Yes No

Party Responsible for billing:

Name: _____ Relationship to patient: _____

Social Security #: _____-_____-_____ Driver's License #: _____

I understand that I am responsible for all amounts due at the time of service. I understand The Center for Children and Families does not file insurance on your behalf. However, you will be provided with an itemized statement in order to file for insurance reimbursement on your own.

_____
Signature

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment, and follow-up among the multiple healthcare providers who may be involved in that treatment directly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read, and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices.**

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:
Relationship to patient:
Signature:
Date:

Office Use Only

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date:	Initials:	Reason:

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FEE SCHEDULE

Initial Assessment	Initial interview, collection and assessment of data. Request for records from previous providers.	$90
Individual Counseling	45 – 50 minutes per session	$90
Group Counseling	60 – 90 minutes per session	$30
Family Counseling	45 – 50 minutes per session	$115
Consultation	Per hour to schools, parents, agencies etc…	$90
Telephone Consultation	Over 10 minutes – No more than 50 minutes	$90
Skype Counseling/Consultation	45 – 50 minutes per session	$90
Preparation of Documents	Work/School/ or other individual or organization as requested. (Minimum of 1 week notice must be given; Does not include school/work excuse forms	$90/hour
Request for Copy of Records	Records sent to individuals/organizations as listed on the Consent For Release of Confidential and Protected Health Information Form	$90

BILLING POLICY

1. Appointments must be cancelled **24 hours in advance** or client **will be charged** the full session fee**.** Payment for sessions cancelled without notice is expected prior to scheduling the next appointment.
2. Fees are to be paid at the time services are rendered. Cash, check, Master Card or Visa are accepted.
3. An encounter form, verifying client's payment for session, is provided should client wish to file an insurance claim.
4. The client or responsible party is ultimately responsible for any fee for services rendered.

I, the undersigned, have read and do agree to the above fee and billing policies of this office.

_____ _____
Signature (Responsible Party) Date

_____ _____
Signature (Witness) Date

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Court Related Fees and Services

- Court testimony costs begin at $250.00 an hour with a minimum charge of three hours. A retainer of $750.00 is due one week prior to the court date. Travel is billed at .50/mile. Failure to provide the specific fees as described constitutes a release from the requested court appearance.
- It is required that a minimum of 36 hours' notice be given if the testimony is not required, otherwise the entire retainer is forfeited. If proper notice is given, the retainer will be refunded.
- Additional services related to court preparation including all correspondence with attorneys or other service providers via phone, email or letter, documentation review and/or documentation preparation are also billed at $250.00 per hour, rounded to the nearest 15-minute increment.
- In cases where a therapist is being contracted to work with a child in a divorce/custody case, a certified copy of the temporary orders or divorce decree must be provided prior to the therapist beginning treatment.

I understand that my fee will be $_____ for each counseling session or $_____ for court related services

_____ _____
Signature (Responsible Party) Date

_____ _____
Signature (Witness) Date

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Parental Consent Form

(For persons under 18 years)

_____has my/our permission to participate in the counseling services provided by Amelia Johnson, LPC-Associate under the supervision of Courtney Suddath, M.A., LSSP, LPC-S. I/we understand that all materials (interview information, test scores, and other personal data) will remain confidential and will not be released to any other agency or person without my/our written consent. My/our written consent to allow the above-named person to participate in these counseling services does not waive any of my/our legal rights.

_____ Parent/Guardian

_____ Address

_____ Parent/Guardian

_____ City/State/Zip Code

_____ Date

_____ (Area Code) Phone Number

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CONSENT FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

In most cases, we feel it is to your advantage that we work with your doctor(s) or others who may have a role in your care. If your therapy concerns a child, it is often helpful for us to have contact with his or her school counselor, teachers, and/or principal.

In order to communicate with these people about you and/or your child, we need your permission. Please sign the release of information below, which allows us to discuss you and/or your child with these people, and/or mail letters/reports to them.

CLIENT NAME: _____ **CLIENT DATE OF BIRTH:** _____

I, _____ (print name) authorize the following mental health care provider and/or organization to disclose and/or use the following confidential patient information to the designated person and/or organization for the purpose(s) listed below.

Information disclosed by:	**Information received by:**
Amelia Johnson, LPC-Associate *Cy-Hope Counseling* (name of provider/organization) _____ (address) _____ (city, state, zip) _____ (fax number) 713-466-1360 (phone number)	_____ (name of provider/organization) _____ (address) _____ (city, state, zip) _____ (fax number) _____ (phone number)
How would you like the information sent? _____ **To be mailed** _____ **To be picked up by** _____ _____ **To be sent via fax** _____ **To be emailed** _____ **Phone consult**	**For the purpose of: (please state) <u>This request and authorization applies to only the following protected health information</u>:** _____ **CONSULTATIONS** _____ **PROGRESS NOTES/SUMMARY** _____ **PSYCHOLOGICAL REPORTS/EVALUATIONS** _____ **BILLING REPORTS** _____ **TREATMENT PROGRESS** _____ **OTHER**

I understand that I may revoke this consent at any time (except to the extent that disclosure has already occurred in reliance upon this consent) by sending a written revocation to the organization designated above.

Otherwise, this authorization is given:
_____ During the following time period or dates: _____ *OR*
_____ Until Termination of Counseling

I understand any information disclosed by this authorization to any person/organization not a health care provider covered by federal and state privacy regulations could be re-disclosed by the recipient and no longer protected by those regulations.

To the receiving party of this information: this information has been disclosed to you for the sole purpose stated in this consent. Any other use of this information without the expressed consent of the patient is prohibited. These records may be protected by federal regulation (42 CFR part 2).

_____
(Patient's Signature) or (Parent/Guardian or Authorized Representative) (Date)

_____
(Therapist Signature) (Date)

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Credit Card Authorization

Please make no marks or add comments to this page of the document. It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modifications. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the case that you miss or fail to cancel an appointment within 24 hours of the scheduled time you will be charged a full session fee. If a check is returned unpaid, you will be charged the full session fee. An additional $25 fee will be assessed for 1) returned checks, and 2) inaccurately disputed claims/charge backs.

Please list **ALL** clients and their date of birth to be authorized to charge session fees on the card listed below:
Client name/s and date of birth:

_____

Address: _____City: _____ St: _____ Zip: _____

Home Phone: _____ Mobile Number: _____
Email: _____

I, _____, hereby authorize Cy-Hope Counseling Center to bill my credit card at the usual fee for professional services including all the following:

- Appointments and/or copayments that I elect to pay for by credit card
- Missed appointments
- Telephone, email or Skype consultations
- Appointments that I have cancelled with less than 24 hours' notice
- Returned checks
- Fees not covered by insurance or insurance payments make to patient rather than provider

Please indicate the form of payment you wish to use for any services rendered through this practice. Fees will be deducted from the designated account at the time services are rendered.

Credit Card Type (Check One): _____ Visa _____MasterCard _____ Discover
Cardholder Information: Please indicate the name and address associated with the credit or debit card you wish to use.

Name on card : _____
Address only needed if CC billing address is different than address listed above.
Address: _____City: _____ St: _____ Zip: _____

By signing this form I am authorizing Cy-Hope Counseling Center to bill my credit card or debit card ending in _____ (provide last 4 digits of the card) at the usual fee for professional services. I will not dispute charges ("Charge Backs") for sessions I have received or appointments I have missed according to the above policy.

_____ _____
Cardholder signature Date

_____
Print Name

Card Type (circle one): **Visa** **MasterCard** **Discover**

Card # _____ Expiration Date: _____

Verification/Security Code (3 digit code on back of card by signature line): _____

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Teletherapy Informed Consent

Client Name: _____ Client Date of Birth: _____

"Teletherapy" includes consultation, treatment, and conversations specific to other medical/psychological information using telephone and video conferencing. Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, teletherapy may be experienced somewhat differently that face-to-face sessions. The client may be asked to register and sign up with a HIPPA compliant teletherapy provider, at no cost to the client.

Teletherapy occurs in the state of Texas and is governed by the laws of Texas and the LPC and LMFT board rules of Texas.

The client has the right to withhold or withdraw consent at any time without affecting the right to future care or treatment.

The laws that protect the confidentiality of medical information also apply to teletherapy. Unless we explicitly agree otherwise with a signed release of confidential information form, our teletherapy exchange is confidential. Your clinician will not include others in the session or have others in the room unless agreed upon through a signed release.

There are some situations where Cy-Hope Counseling is permitted or required to disclose information without either a consent or a Release of Information. These include:

1. If a client is involved in a court proceeding and a request is made for information concerning the client. Cy-Hope Counseling cannot provide any information without the client's or client's legal representative's written authorization. However, if Cy-Hope Counseling receives a court order, Cy-Hope Counseling may disclose information without the client's consent or authorization. If the client is involved in or contemplating litigation, the client should consult his/her attorney to determine whether a court would likely order Cy-Hope Counseling to disclose information.
2. If the client's records are subpoenaed as part of a criminal investigation, Cy-Hope Counseling must disclose the client's records without the client's consent or authorization.
3. If a client files a complaint or lawsuit against Cy-Hope Counseling, Cy-Hope Counseling may disclose relevant information regarding the client without the client's consent or authorization in order to defend itself.

There are some situations in which Cy-Hope Counseling is legally obligated to take action. These include:

1. If Cy-Hope Counseling has cause to believe a child under age 18 has been or is at risk to be abused or neglected (e.g. physical injury, a 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 Cy-Hope Counseling to make a report to the appropriate governmental agency. This is usually the Texas Department of Family and Protective Services. Once such a report is filed, Cy-Hope Counseling may be required to provide additional information to this agency.
2. If during the course of counseling Cy-Hope Counseling learns that a client has been sexually abused or exploited by a mental health professional, state law requires Cy-Hope Counseling to report this information to law enforcement and the professional's licensing board.
3. If Cy-Hope Counseling determines that there is a probability that the client is in imminent danger of harming himself/herself or others, Cy-Hope Counseling may contact family members or others (e.g. medical, mental health, or law enforcement personnel) to provide protection for the threatened individuals.

Teletherapy does not provide emergency services. If you are experiencing an emergency situation, please call 911 or proceed to the nearest hospital emergency room for help.

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In the event that our teletherapy is not in the best interest of a client, the clinician will explain that to the client and suggest some alternatives that would be best suited to the client's needs.

There are some potential concerns about the delivery of services vie remote or electronic means which include: the potential lack of confidentiality and privacy despite the efforts of the clinician; the transmission of information could be disrupted or distorted by technical failures; the transmission of information could be unintentionally interrupted by unauthorized persons. The clinician is responsible for providing a HIPPA protected option for teletherapy and for information security on their computer. The client is responsible for information security on their computer.

I have read, understand and agree to the information provided above regarding telehealth:

Client's Signature: _____ Date: _____

Clinician's Signature: _____ Date: _____