



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 from Olivet Nazarene University with a B.A. in Education. I am presently earning practical experience to complete my Master's degree in Counseling at the University of Houston-Victoria. My current role at Cy-Hope Counseling Center is a Practicum Student working toward becoming a Licensed Professional Counselor. While I will be your main point of contact, I am supervised by Courtney Suddath, M.A., LSSP, LPC, and she can be contacted through The Cy-Hope Counseling Center, 713.466.1360. 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:

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, The Center for Children and Families 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.

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

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

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

Client/Parent/Guardian Signature

Date

Therapist Signature

Date



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

Parent Name

Address: _____

Address: _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Email: _____

Email: _____

Primary Phone: _____

Primary Phone: _____

Cell Phone: _____

Cell Phone: _____

Texting OK? Yes No

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



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.	\$50
Individual Counseling	45 – 50 minutes per session	\$50
Group Counseling	60 – 90 minutes per session	\$37.50
Family Counseling	45 – 50 minutes per session	\$50
Consultation	Per hour to schools, parents, agencies etc...	\$50
Telephone Consultation	Over 10 minutes – No more than 50 minutes	\$50
Skype Counseling/ Consultation	45 – 50 minutes per session	\$50
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	\$50/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	\$25

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



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



Informed Consent to Audiotape or Videotape Counseling Sessions

Cy-Hope Counseling provides a variety of services to individuals and their families. It also supports the teaching and training mission of licensed interns and practicum students. Because The Center provides a teaching-training function, permission is frequently requested of its clients to audiotape and/or videotape the counseling sessions that are conducted by the professionals-in-training. Audio taping and video recording the sessions are a significant component of counselor training. However, no recording is ever done unless the client has given permission to do so. Therefore, we use this consent form to obtain your permission to audiotape and/or video. Feel free to ask your counselor any questions about the purpose of taping and use of the tapes.

Your signature below indicates that you give Doug Harbrueger permission to be audiotaped / videotaped (circle one or both) and that you understand the following:

1. I can request that the tape recorder or video recorder be turned off at any time and may request that the tape or any portion thereof be erased. I may terminate this permission to tape at any time.
2. The purpose of taping is for use in training and supervision. This will allow the above referenced counselor-in-training to consult with her assigned supervisor(s) in an individual or group supervision format, who may listen to the tape alone or in the presence of other counselors-in-training involved in direct supervision.
3. The contents of these taped sessions are confidential and the information will not be shared outside the context of individual and group supervision.
4. The tapes will be stored in a secure location and will not be used for any other purpose without my explicit written permission.
5. The tapes will be erased after they have served their purpose.

Name of Client (Please print)

Signature of Responsible Party

Date



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.

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.

<p>Information disclosed by:</p> <p>_____</p> <p>(name of provider/organization)</p> <p>_____</p> <p>(address)</p> <p>_____</p> <p>(city, state, zip)</p> <p>_____ 713-466-1360 _____</p> <p>(fax number) (phone number)</p>	<p>Information received by:</p> <p>_____</p> <p>(name of provider/organization)</p> <p>_____</p> <p>(address)</p> <p>_____</p> <p>(city, state, zip)</p> <p>_____ (fax number) _____ (phone number)</p>
<p>How would you like the information sent?</p> <p>_____ To be mailed</p> <p>_____ To be picked up by</p> <p>_____ To be sent via fax</p>	<p>For the purpose of: (please state) <u>This request and authorization applies to only the following protected health information:</u></p> <p>_____ CONSULTATIONS</p> <p>_____ PROGRESS NOTES/SUMMARY</p> <p>_____ PSYCHOLOGICAL REPORTS/EVALUATIONS</p> <p>_____ BILLING REPORTS</p> <p>_____ TREATMENT PROGRESS</p> <p>_____ OTHER</p>
<p>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.</p>	
<p>Otherwise, this authorization is given:</p> <p>_____ During the following time period or dates: _____ <i>OR</i></p> <p>_____ Until Termination of Counseling</p>	
<p>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.</p>	

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)

(Witness Signature) (Date)



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 The Center for Children and Families, A 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 made 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 The Center for Children and Families, A 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): _____