Stepping Forward Christian Counseling

FM 2252 Suite 15, Garden Ridge, TX 78266 Phone (210) 338-0191 Fax (210) 281-5108

INFORMATION AND AUTHORIZATION FORM FOR
Cassidy Tolopka, MA, LPC-INTERN

Client Name:_____ **Date of Birth:**_____ **Age:**_____
Social Security #: _____ **Sex: M or F Marital Status:** _____
Address: _____ **City:**_____ **Zip:**_____
Contact phone number: _____ **Email address:**_____
Employer or School:_____ **How did you hear about us?**_____
Name & Address (or phone #) of Physician/Psychiatrist (please complete "Authorization to Confer" on following page):_____

I understand that I (or my child) am seeing an Intern, Cassidy Tolopka, MA, LPC-Intern under the Supervision of Kelly S. Zentner, MA, LPC-S at Stepping Forward Christian Counseling. I understand that they regularly consult on this case and that I may contact the supervisor at (210) 833-1900 if I have any issues or questions. I also understand that they meet weekly to discuss my case, as well as others.

Printed name: _____ **Relationship:**_____

Signature: _____ **Date:**_____

EMERGENCY CONTACT:

Name:_____ **Phone Number:**_____

Secondary Phone Number: _____ **Relationship to Client:**_____

As part of professional training, LPC-Interns are required to complete 3000 hours of counseling. During this time, Interns may not charge insurance. Therefore, I am signing here agreeing that I am choosing to NOT USE MY INSURANCE and that we are agreeing to a "Full Fee" rate of $_____ **per session.**

Signature: _____ **Date:**_____

I understand that the billing agent, Inside Billing Out, will be handling the billing for my account and if I have any questions, I may contact them at 830-214-6111.

Signature: _____ **Date:**_____

Diag code (therapist will fill out) 1)_____ **2)** _____ **3)** _____ **4)** _____

CONFIDENTIAL CLIENT INFORMATION

Client Name: _____ **Ethnicity:** _____

Primary Issue: _____

_____

_____

Are you currently receiving treatment for an illness, injury or other medical condition? _____

_____

_____

Are you currently taking any prescribed medications? If yes, please list names and use:

_____

_____

How often do you drink alcohol? ___ Never ___ Seldom ___ Occasionally ___Often ___Daily
How often do you smoke marijuana? ___ Never ___ Seldom ___ Occasionally ___Often ___Daily
Other recreational drugs used? _____

Brief Mast

1.	Do you feel you are a normal drinker?	YES	NO
2.	Do friends or relatives think you are a normal drinker?	YES	NO
3.	Have you ever attended a meeting of Alcoholics Anonymous (AA)?	YES	NO
4.	Have you ever lost friends or girlfriends/boyfriends because of your drinking?	YES	NO
5.	Have you ever gotten into trouble because of your drinking?	YES	NO
6.	Have you ever neglected your obligations, your family, or your work for two or more days in a row because of your drinking?	YES	NO
7.	Have you ever had delirium tremors (DTs), severe shaking, heard voices, or see things that weren't there after heavy drinking?	YES	NO
8.	Have you ever blacked out and not known where you are after drinking?	YES	NO
9.	Have you ever been in a hospital because of your drinking?	YES	NO
10.	Have you ever been arrested for drunk driving or driving after drinking?	YES	NO

Legal Issues and History: Please tell us if you have any current legal issues (arrests, convictions, civil or criminal lawsuits, and judgements, order of protection, juvenile delinquency or pending or probably legal situations): _____

_____

_____

Are you having suicidal thoughts? Yes or No If yes, Do you have a plan? Yes or No
Have you ever had suicidal thoughts? Yes or No Please explain: _____

_____

Have you ever attempted suicide? Yes or No If yes, how many times? _____
Have you ever been to counseling before? Yes or No If yes, who with? _____

_____

What are your goals for therapy? _____

_____

_____

What do you consider are your strengths? _____

_____

What do you consider are your weaknesses? _____

_____

Have you ever had an abortion or miscarriage? _____

_____

Any recent deaths in your personal world (including pets)? _____

_____

Please circle any of the feelings or issues that you are having from the list below:

worried	overwhelmed	worthless	lonely	desperate
anxious	"don't care" attitude	lethargic	tired	unstable
distracted	lack concentration	sad	sleep a lot	hardly sleep
impatient	overly confident	fight a lot	agitated	angry
manic	troubled relationship	hyper	racing thoughts	fidgety
lying	poor self-esteem	moody	intense	defiant
stealing	afraid to be alone	chews nails	overly focused	cutting
migraines	stomach issues	dizziness	memory loss	confused
unloved	sexual problems	shyhopeless	ashamed	helpless
avoid others	don't like others	other:_____		

_____

Briefly describe what it was like growing up in your home: _____

_____

_____

_____

Any hospitalizations, trauma (including sexual or physical) in your/child's history? _____

_____

_____

Status (please circle all that apply): MARRIED DIVORCED SINGLE COHABITATING

Current Spouse/Partner: _____ **Their Age:** _____

Occupation: _____ **Years Married/Together:** _____

Children (list name and ages. For child clients please list siblings): _____

_____

With whom do you live with now?_____

Any family history of mental or emotional illness? _____

_____

The above information is true and correct to the best of my knowledge.

_____ _____

Printed Name of Person Completing the Form **Date**

_____ _____

Signature of Person Completing the Form **Date**

Circle relation below:

Self Parent Spouse Other

Grandparent Significant Other

Credit Card Information and Authorization

Credit Card Authorization Form

I, _____, hereby authorize Stepping Forward Christian Counseling to bill my credit card as listed below for the professional fees for myself or my family member.

If you need to cancel or reschedule an appointment, please give 24-hour advance notice, otherwise you will be charged at my FULL FEE hourly rate. If I do not hear from you BEFORE your missed appointment, your credit card will be charged. If you need to cancel or are going to be late, please contact me. If you arrive late, the session will end at the scheduled time. If I haven't been informed that you will be late and you haven't appeared 15 minutes after your scheduled time, I may leave the office and you will be charged as a "no show".

I agree that Stepping Forward Christian Counseling may bill my credit card for the professional services including the following:

(please initial each line)

_____ Appointments that have not been paid by cash or check. (Full Fee)

_____ Missed appointments. (I understand they will be charged at Full Fee).

_____ Appointments I have cancelled with less than 24-hours' notice. (Full Fee)

_____ Telephone Consultations that exceed 15 minutes. (billed in 15 minute increments based on my Full Fee)

_____ Copying of file. ($1.00 per page or other agreed upon rate at time requested)

_____ Completing/creating paperwork or forms. (that we have agreed upon at time requested)

I also agree that my credit card may be charged for the following:

_____ Balances of charges not paid by me.

_____ Insufficient funds/returned checks and bank charges for those fees.

Type of Card (check one):

____ Visa ____ MasterCard ____ American Express ____Discover

Name as it appears on card: _____

Card Number: _____

Expiration Number: _____

CVV2/CID Security Code: _____

Zip code on billing address of card: _____

Signature: _____

Date of Signature: _____

Charges will appear on your credit card or bank statement as Stepping Forward Christian Counseling or some variation of this name.

Stepping Forward Christian Counseling
19115 FM 2252 Suite 15
Garden Ridge, TX 78266
Phone (210) 338-0191
Fax (210) 281-5108

Authorization to Confer

Name of Client: _____

Date of Birth: _____

I hereby authorize Cassidy Tolopka, MA, LPC-Intern under the supervision of Kelly S. Zentner, MA, LPC-S and

(physician or psychiatrist) _____

At (phone # or address) _____

to confer with each other, in their professional capacity, regarding my case. This specifically includes information derived from psychological testing, diagnostic interviews, and medication evaluations.

_____
Signature

_____
Date

Agreement to Standards and Policies for Stepping Forward Christian Counseling

I have enclosed a packet about Stepping Forward Christian Counseling and its policies, rules, standards and guidelines. I have also included a HIPPA packet discussing your rights to privacy. This form indicates that highlighted portions of those packets and your understanding of our agreed upon contract. Please read the packet and then initial each line to indicate that you agree to these standards. I will gladly answer any questions you may have about the packets or my policies, please do not hesitate to ask if you are need more information for clarification.

_____ **My therapist, Cassidy Tolopka, MA, LPC-Intern**: I understand that Cassidy Tolopka, MA, LPC-Intern is a Licensed Professional Counselor-Intern in the state of Texas and has a supervisor, Kelly S. Zentner, MA, LPC-S. I also understand that Cassidy Tolopka, MA, LPC-Intern is not a psychiatrist, she is a Master's level therapist, and as such cannot recommend or prescribe medications, but can encourage clients to see an MD for a medication evaluation. I also understand that my therapist works with children, adolescents and adults in individual, group and family counseling. I understand that Licensed Professional Counselors do not perform formal testing but refers individuals to those who do. I also understand that she is a Christian counselor, she is available to help clients with spiritual issues and/or incorporate spiritual guidance into the counseling process, if desired by me.

_____ **Counseling**: I understand that as my therapist, or the therapist working with my child, I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship. I also understand that when my therapist sees members from the same family, She uses her professional judgment as to when to share concepts about the family dynamics or the other family members. I also understand that counseling can improve as well as upset the equilibrium in any person or family. I also understand that I have a right to my clinical records, but usually they are sent to other professionals due to the sensitive material.

_____ **Clients' Rights**: I understand that if any assignment is given that I disagree with morally, ethically or emotionally, I have the right not to proceed in that assignment. I also understand that if I am concerned about slow progress or lack of progress, I have the right to speak to my therapist about this matter. I understand that if I have a complaint I cannot resolve with my therapist or the supervisor then I may wish to file a formal complaint, I may contact the Texas State Board of Examiners of Licensed Professional Counselors at the number and address listed in the packet.

_____ **Limits of Confidentiality**: I understand that there are some occasions when confidentiality can/must be breached. Those are a) I request my therapist to talk to someone else in writing or verbally, b) my therapist determines that the client poses a threat to themselves or others, c) the court orders information to be disclosed, or d) my therapist suspects that child/elderly abuse has taken place, at which time Child/Elderly Protection Services will be notified. I also understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality. I also understand that my therapist may consult with another professional to help with my case and that confidentiality is still held to the highest of standards during the process.

_____ **Finances**: I understand that I am responsible for all fees and balances on my account. I understand that the rate for sessions is $_____. These fees are for a routine session of 53 minutes. I understand that all payments are due at the time of service. I understand that there is a returned check fee of $25. I understand I am releasing my right to bill insurance and option to pay privately.

_____ **Billing Company**: I understand that INSIDE BILLING OUT will be handling my billing needs including. I understand that if I do not pay my outstanding balance that bill collectors will be used to collect.

_____ **Cell Phone Usage:** I understand that much of my therapist's contact with me is via the use of a cellular phone (for phone calls, voice mail, calendars and texting) and that my confidential and privacy are at risk due to these electronic devices.

_____ **Court Involvement**: I understand that my therapist does not knowingly accept court-related cases and I am not in a court related situation and will not call my therapist to be involved if one begins.

_____ **Custody**: By initialing on the line, I am stating that I have custodial rights to seek mental services for my child. I will give information to my counselor to contact the other parent. I will also provide court documentation proving my right to bring this child in for services.

_____ **Treatment of Minor**: I understand I have rights to my child's records, however, I am giving up those rights to protect their privacy and my therapist will occasionally share summaries and thoughts as necessary. I also understand that my therapist may know that my child is doing destructive behaviors (i.e. using drugs/alcohol, cutting, having sex, etc.) and may not tell me as they process and work on coping and/ or exposing the behavior. I also understand the statements above about professional judgement and about sharing information when counseling other family members.

_____ **Emergencies**: I understand that my therapist may not be able to get back to me immediately or for several hours and I have the choice of waiting for the return call, calling 911, or getting to the nearest emergency center for immediate care. I also understand that in the event Cassidy Tolopka, MA, LPC-Intern dies or is unable to continue providing clinical services, Kelly S. Zentner, MA, LPC-S, is designated as conservator for my patient records. She will help you find a therapist to continue the services, if desired. Upon receipt of written request, she will make these records available to you or a mental health provider of your choice.

_____ **HIPPA Packet**: I did receive a packet with all of this information and a packet with my rights for HIPPA.

By signing below, I confirm that I have read, initialed, agreed to, and received the above information in my packet.

_____ _____

Client/Parent of Client Signature Date Received and Read

Stepping Forward Christian Counseling
Cassidy Tolopka, MA, LPC-Intern
19115 FM 2252 Suite 15 Garden Ridge, Texas 78266
Phone (210) 338-0191 Fax (210) 281-5108
E-mail: cassidy.tolopka@gmail.com

Client Services Agreement

Welcome to my practice! I am a Licensed Professional Counselor-Intern, known as an LPC-Intern. I perform counseling services and am under the supervision of Kelly S. Zentner, MA, LPC-S. I cannot prescribe any medications nor advise you on how to handle your medications. I can help you find someone if we feel that is necessary. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. **The law requires that I obtain your signature acknowledging that I have provided you with this information.** Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, **you may experience uncomfortable feelings** like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. **But there are no guarantees of what you will experience.**

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them 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. Please understand you may stop using my services at any time. However, if I believe you are a threat to yourself or others, I will be forced to take action (as described below). During our time together, I may work with other family members with your knowledge and permission. Please understand that sometimes I may share general concepts or my theories with one or the other of you. I always use my professional judgment and will never share in order to hurt you or your family. My ultimate goal is to help everyone understand the situation and understand one another better.

As you noticed, this is a Christian counseling office and I am a Christian. This means I have Christian morals and beliefs and come from that point of view in our sessions. That DOES NOT mean I will judge you, convert you or convince you to match my beliefs. If you would like to include God and Jesus into our discussions, I will gladly accommodate you in that way. However, if you choose to have more of a secular approach to counseling and to leave that piece out of your or your child's sessions, I can certainly accommodate that request as well.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy has begun, I will usually schedule one 53-minute session) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled**, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation** [unless we both agree that you were unable to attend due to circumstances beyond your control]. [If it is possible, I will try to find another time to reschedule the appointment.] Also, please keep in mind if you are more than 15 minutes late, I will typically leave and you will be charged for a NO SHOW visit. However, if I am running behind due to a possible crisis, I request that you stay, if possible, and I will still give you your full 53 minutes.

If we happen to run into one another out in a social situation, please understand that you and your confidentiality are my priority, so I will NOT address you or show that I know you. It is up to you of how you would like to handle this relationship once we are in public and I will follow your lead. Keep in mind, due to the professionalism of our relationship we will not be able to be friends or have social interactions intentionally.

Many times, I give homework for you to work on, if for any reason you disagree with the assignment for moral, ethical, or emotional reasons please tell me and I will give a different assignment. You do not have to do anything you are uncomfortable with, but please keep in mind some uncomfortable situations could be a signal that something really needs to be worked on. This counseling process is at your pace and your direction. I will certainly try to accommodate at each step. Keep in mind, I have an aggressive style that sometimes you may not like. Please tell me and we can work on things, or I can help you find someone that would be a better fit for your personality style.

PAYMENT AND PROFESSIONAL FEES

My hourly fee is $80.00 for the initial diagnostic session and $70.00 for the 53 minutes. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. 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. Please see section about court appearances for specific details of my involvement.

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. [In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.]

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, address, phone numbers, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone and I will not answer the phone when I am with a client. When I am unavailable, please leave a confidential voicemail and I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. You may also text me about appointments or quick information, please realize the limits of confidentiality with contact via texting. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the person on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. Please understand that contact outside of face-to-face sessions is done on cordless and cellular phones. All conversations via these means have limited privacy.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a psychotherapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a 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 confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.
- All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without my permission.
- I also have contracts with a billing agency, computer services, and collection agency. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- 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 by the client to the client or others, or there is a probability of immediate mental or emotional injury to the client.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

- If I have cause to believe that a child under 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, or 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, usually the Department of Protective and Regulatory Services. Once such report is filed, I may be required to provide additional information.
- If I determine that there is a probability that the client will inflict imminent physical injury on another, or that the client will inflict imminent physical, mental or emotional harm upon him/herself, or others, I may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the client.

If such a situation arises, 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.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep a Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. You should be aware that pursuant to Texas law, psychological test data are not part of a client's record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of $1.00 per page (and for certain other expenses). The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Record, you have a right of review, which I will discuss with you upon your request.

If anything ever happens to me where I am incapacitated and unable to care for your records, Kelly S. Zentner, MA, LPC-S at (210) 833-1900 will have access to retrieve your records. She will not be taking over the case but she will help you find someone who can help.

CLIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.

If you wish to contact my licensing board the address is as follows: Texas State Board of Examiners of Professional Counselors at PO Box 141369, Austin, Texas, 78714-1369. Their phone number is (800) 942-5540. My license is number is TX 82091 .

MINORS & PARENTS

Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. However, if the treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse, the law provides that parents may not access their child's records. For children between 12 and 18, because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from the client and his/her parents that the parents' consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

If your child is from a separated, divorced or soon to be divorced/separated family, I will need to see proof that you have legal right to bring the child to receive mental health services. I always attempt to keep all parties involved in counseling with a child. However, I will not force a parent to be a part of the process; it is just highly recommended. I do ask that I have contact information for both sets of parents and the right to visit with them about the child; unless, the courts stipulate differently. I will follow all court mandated orders.

Keep in mind, that I may know that a child/adolescent is demonstrating destructive behaviors like sex, cutting, using drugs or alcohol, etc. and I may not discuss the matter with the parents. My goal is to build a communication bridge between the child and the parent, so I will be working on the child to tell the parent about the behavior or work on the child to cease the behavior. I am requesting you to trust my professional judgement in this matter.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. Due to me being an Intern, I cannot bill insurance. This provides extra privacy for you due to no insurance company having access to your information and no paper trail about your mental health coverage in the electronic medical billing world. My billing company, Inside Billing Out, will be able to handle most of your financial question, feel free to call them at 830-214-6111 or email at insidebillingout@gmail.com if you have questions or concerns.

Court Involvement and Subpoenas

I do not knowingly accept court-related cases. Your signature serves as your agreement that you are not involved in a court-related case regarding the circumstances in which you are seeking counseling. **I am not a custody evaluator and cannot make any recommendations on custody matters. I can refer you to a professional who can provide custody evaluation if needed.** Due to the sensitive nature of court related issues, and the time that it will cost me away from my normal work day, you must agree to the following policies before:

- When working with children of divorced parents, I require a copy of the current, standing court order that demonstrates custodial rights of each parent; or a parenting agreement that has been signed by both parents and a judge before I meet with the child. The parent who is initiating counseling services must have legal authority to make medical decisions for the child. It is your responsibility to inform the other parent of your child's involvement in counseling if necessary. It is optimal for both parents to participate in the counseling process if possible. I will offer and encourage opportunities for both parents to be involved throughout the counseling process.
- I ask that my clients waive their right to subpoena me to court for any reason. It is my desire and ethical obligation to preserve the confidentiality and trust that is established in the counseling relationship. Having me and/or my records subpoenaed often damages this. It is in your best interest to know that conducting expert witness testimony is not my area of expertise. I can refer you to another professional who can provide this service if needed. Your signature indicates your agreement to waive your right to subpoena me for this purpose.
- I will not attend court or deliver my records unless a valid subpoena is issued. If you choose to disregard this waiver and issue me a subpoena, you will be responsible for all charges involved. If you or your child become involved in legal proceedings that require my participation from another party, you will be responsible for all charges.
- **Court related services are not covered by insurance.** If I am subpoenaed to appear in court, it will be necessary for me to clear my schedule to be available to attend. I will require at least 24 hours advance notice in order to do this. **The charge for me to clear my schedule is $1000, regardless of whether or not I am actually called to appear in court.** This includes time spent "on call" or "on standby". This fee is not refundable even if the case is dismissed or court date is rescheduled.
- **My fee for attending court is $3000 per day regardless of how long I am there or if my services are used.** The advance payment of $1000 to clear my schedule will apply towards the daily fee if I am indeed required to attend court on that day. Other expenses such a preparation for court, researching, report writing, depositions, travel time, and communicating with attorneys or other professionals will cost an additional $250 per hour, and is not included in the $3000 per day fee. Other expenses such as transportation costs, lodging (if more than 90 minutes away from my office), copies, and parking will be charged separately. In the event that I must seek legal consultation regarding any issues involving you or your child, you will be responsible for any charges incurred. All payments must be made in advance in the form of cash, or cashier's check. Checks will not be accepted.

Notice of Policies and Practices to Protect the Privacy of Your Health Information (HIPPA)

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 operations 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. Client's Rights and Psychologist's Duties

Client'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 Kelly S. Zentner, MA, LPC-S, Owner, 210-833-1900. 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 Kelly S. Zentner, MA, LPC-S, 19115 FM 2252, Ste 15 Garden Ridge, TX 78266, 210-833-1900. 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 October 10, 2017. 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.