Client Services Agreement
Policies and Procedures

Welcome to the *Caldwell Counseling Center*. This 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 privacy protections and patient 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. Please refer to the Notice of Privacy Practices in your intake paperwork. Please take time to read this thoroughly as this highlights your expectations upon entering the counseling relationship as well as your rights as a client. Thank you for choosing *Caldwell Counseling Center*. I am looking forward to working with you!

Cancellation Policy: Please help us to serve you and others better by keeping your scheduled appointments. If you need to cancel or reschedule please give us as much notice as possible so we can give that time to someone else. Unless cancelled 24 hours in advanced, our policy is to charge $75.00 for the missed appointment. This will be billed to you and we may require payment in full in order to schedule a subsequent appointment. Clients who repeatedly miss appointments may be discharged from services.

Communication: You may leave a message for me at any time on my confidential voicemail. Please understand that as a solo, outpatient practitioner, I am unable to personally provide continuous 24-hour crisis services. Calls/texts are generally returned within 24 hours during normal workdays (Monday through Friday). Some clients prefer to communicate about appointment times or other administrative issues via e-mail. E-mail transmitted through regular services is not encrypted. This means that a third party may be able to access information in an e-mail and read it, since it is transmitted over the Internet. E-mail should be considered to be more similar to a "post-card" than to a sealed letter, and for that reason I discourage sending any clinical or other sensitive information via e-mail. Please use the telephone for anything urgent or time sensitive, as I cannot guarantee that I will see an emergency email. You will note your communication preferences in the intake section of this form.

Confidentiality: Your counselor will not share any information with any person outside of the Caldwell Counseling Center except when required by law or when given written permission by you on a Release of Information (ROI) document. Information from minors is not generally shared with parents without permission from the client. HIPPA laws allow you access to your file and protect the electronic transfer of information.

Exceptions to Confidentiality: Federal regulations do not protect from disclosure of information related to a client's involvement in a crime against property or personnel. We are required under State law to report suspected abuse of a child, elderly person, individual with a disability, or animals. We may share limited information in the event of a medical emergency or in the event of a specialized court order signed by a judge. Your counselor has the option of breeching confidentiality if you report a specific plan or intent to harm yourself or any other identifiable person. We may share case specifics in a supervision setting.

Emergency: If you are experiencing an emergency, please call 9-1-1 and/or go to the nearest emergency room.

Financial Policy: Full payment is due at time of service (unless prior arrangements have been made). Please feel free to ask if you have any questions about our financial policy. Understanding our financial policy is important to our relationship. You are responsible for the timely payment of your account. Uncollected balances may be turned over for collection or reported to the state's attorney's office.

Litigation: I will not voluntarily participate in any litigation or custody dispute in which you and another individual, or entity, are parties. I have a policy of not communicating with client's attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in any client's legal matters. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate for such services of **$100 per hour** (normal cost associated with what would be time spent counseling others).

Professional Records: You should be aware that, pursuant to HIPAA, I keep PHI about you- your 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 other professionals including primary care physicians, Psychiatrist, and other referrals. 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.

Session Length & Fees: Appointments are made by calling 832-443-2983, Monday through Friday between the hours of 8:00 am and 5:00 pm. Each session is approximately 45-50 minutes in length at a rate of $100 per session. Any sessions with more than two family members will be $150 per session and may run longer in time up to 75 minutes. If you arrive late to your session, that time will be taken out of our meeting. We will consider you a "no show" if you have not arrived or called 15 minutes past our appointment time and you will be charged for that time. Please refer to the cancelation policy above.

- **First Session:** Our initial meeting is for gathering information, setting goals and talking about ways that we might go about meeting them. If you don't want to continue treatment with us, please let us know within seven days of our initial meeting and we will provide referrals.

Social Media Policy: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Instagram, Twitter, Snapchat, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, as with anything, please bring them up when we meet and we can talk more about it.

Termination: "Ideally, termination of the counseling relationship occurs when the goals that are mutually agreed upon by the clinician and the client have been achieved, or the problem for which a client has entered into counseling has become more manageable or is resolved" (Syracuse University 2019). You have the right to terminate our relationship at any time, for any reason and you normally will be the one to terminate our therapeutic relationship with these exceptions:

- If I believe my training and/or skills are not a fit for your therapeutic needs. In this case, I will attempt to refer you to another counselor or therapist who I hope will meet your needs.
- If you threaten verbally/physically harass and/or do violence to me/my family I will terminate our therapeutic relationship unilaterally and immediately.

Receipt of Policies and Procedures

I acknowledge I have read and understand *Caldwell Counseling Center's* Policies and Procedures.

____

Individual or Legal Representative Printed Name Date

____

Individual or Legal Representative Signature Date

Client – Counselor Services Agreement

HIPAA Notice of Privacy Practices

Effective Date: 08/2019

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully. "**Use and disclosure of protected health information for the purposes of providing services.** Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes."

1. Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the client.

2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made, they will be disclosed to you or your legal representative unless disclosure increases risk of further

3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in Sections 1 and Sections 2.

4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at any time. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request and 60 days if the records are stored off site.

5. You may request corrections to your records.

6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.

7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request review of the denial. A review will be conducted by another licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.

8. You may request that we restrict uses and disclosures outlined in Section 1. However, we are not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, we will be bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. We may also revoke such restrictions but information gathered while required by law or in an emergency. We may also revoke such restrictions but information gathered while the restriction was in place will remain restricted by such an agreement.

9. If you wish to complain about privacy or related issues with counselor, you may contact:
    - Complaints Management and Investigation Section
      P.O. Box 141369
      Austin, Texas 78714-1369
      1-800-942-5540
    - In any case there will not be any retaliation against you or your legal representative for filing a complaint.

10. This agreement may be modified or amended as required by law or in the course of health care operations.

Receipt of HIPAA Notice of Privacy Practices

I acknowledge I have read and understand this privacy notice and my rights concerning use and disclosure of protected health care information

____

Individual or Legal Representative Printed Name Date

____

Individual or Legal Representative Signature Date

Client - Counselor Services Agreement

Client Rights & Responsibilities

We want you to be aware of your rights as a client of our service. The following is a summary of your rights based on the Texas law called the Patient's Bill of Rights. We have outlined these below, and invite you to ask your counselor if you have any questions about these rights. Following that, there is a list of your responsibilities to help us give you the best care we can.

Client Rights

1. You have the right to have all of your information from the beginning of the counseling process kept confidential with few exceptions. Please see Client - Counselor Services Agreement/Policies and Procedures.
2. You have the right to discuss with your counselor what information is in your record, and if you sign a release of information authorizing *Caldwell Counseling Center* to share information with outside sources, you have a right to discuss specifically what information will be released.
3. You have the right to end your counseling at any time without any additional moral, legal, or financial obligations and have *Caldwell Counseling Center* provide referrals to other treatment options.
4. You have the right to participate in the counseling process that may include external work that may include workbooks, etc, you have the right not to participate in these activities.
5. You always maintain the right to question any aspect of the counseling process.
6. You have the right to know the credentials of your therapist.
7. You have the right to present a complaint, knowing that your care will not be compromised in any way. If you have a problem concerning your care, please try and work with counselor first and if you cannot solve with your counselor, contact P.O. Box 141369, Austin, Texas 78714-1369, 1-800-942-5540.

.

Client Responsibilities

1. Keep your scheduled appointments and let us know as soon as possible if you cannot keep an appointment (See Cancelation Policy)
2. Be as honest and open as possible with your counselor.
3. Between sessions, think through the concerns you are addressing in counseling.
4. Follow through on treatment recommendations and complete your counseling external work assignments.
5. We ask that you end your work with us in a termination session, rather than not keeping your appointment. This way you can share and discuss with your counselor what was useful and what could have been improved.
6. If you feel that you might harm yourself or others, contact 911 or go to the nearest hospital.
7. Keep your information updated, and informing therapist of any changes.

Receipt of Client Rights & Responsibilities

I acknowledge I have read and understand the Client Rights & Responsibilities.

____

Individual or Legal Representative Printed Name Date

____

Individual or Legal Representative Signature Date

Consent for Treatment

I have read *Caldwell Counseling Center's* Client-Counselor Agreement statement that includes the policies and business practices in its entirety. I understand the limits of confidentiality required by law as written in the Client-Counselor Agreement statement/Policies & Procedures. I agree to pay the fees associated with the counseling practice as written in the Client-Counselor Agreement statement/Policies & Procedures. If I miss a session without canceling, or cancel with less than twenty-four hours' notice, I understand I will pay the designated amount as written in the Client-Counselor Agreement statement/Policies & Procedures. I understand my rights and responsibilities as a client, and my counselors' responsibilities to me and confidentiality of our sessions as written in the Client-Counselor Agreement statement/Notice of Privacy Practices/Client Rights. I understand I can withdraw this consent at any time ending the therapeutic relationship. I consent to engage in the counseling process with *Caldwell Counseling Center*.

____

Individual or Legal Representative Printed Name   Date

____

Individual or Legal Representative Signature   Date

Client Intake Form

Name:____ Date:____________________________

Preferred Name: ____

DOB: ____________________ Age: _________

Address:____This is my home: ☐ Yes ☐ No

City: ______________________ State: ________Zip:____

Preferred Contact #:____

Alternative #____

May we contact you at the listed numbers and leave a discreet voicemail? ☐ Yes ☐ No

Preferred Email: ____

☐ I do not wish to receive any counseling-related information via e-mail.
☐ I understand the risks of unencrypted e-mail, and do hereby give permission for *Caldwell Counseling Center* to contact me or to reply to me via unencrypted e-mail. Please provide preferred e-mail address below.

Name and number of Emergency Contact: ____

Marital Status: ☐ Married ☐ Engaged ☐ Single ☐ Separated ☐ Divorced

Do you currently have, or have ever had children? ☐ Yes ☐ No

If yes, please explain: ____

I am currently employed ☐ Yes ☐ No

If yes, name of employer/job title: ____

How did you hear about *Caldwell Counseling Center*? ______________________________________

Briefly describe the issues/problems that led you to seek counseling today: _____________________

____

____

List two goals you would like to achieve in counseling: ___________________________________

____

____

Describe any health-related problems, medical conditions, or operations (current/past): ______________________

____

List all medications you are current taking: ____

____

☐ I am taking the medication as prescribed by my doctor.

Primary Care Physician's Name & Number: ____

List any past Psychiatric/Counseling/SUD Treatment you've had: ______________________________________

____

Are you currently seeing a therapist? ☐ Yes ☐ No

If yes, please explain ____

Have you ever had suicidal thoughts or homicidal thoughts (SI/HI)? ☐ Yes ☐ No

If yes, please explain: ____

Are you current experiencing SI/HI? ☐ Yes ☐ No

Have you ever had thoughts of self-harm (cutting, etc)? ☐ Yes ☐ No

Do you believe in a Higher Power? ☐ Yes ☐ No

Do you have a religious affiliation? ☐ Yes ☐ No

If yes, please explain: ____

How often do you drink alcohol? ☐ None ☐ Daily ☐ 1-2x weekly ☐ 3-4x weekly ☐ more than 5x weekly

How often do you use drugs (illicit/prescription drugs)? ☐ None ☐ Daily ☐ 1-2x p/w ☐ 3-4x p/w ☐ 5-6x p/w

List current and past drug use: ____

____

CAGE-AID I-IV

I. Have you ever felt you should cut down on your drinking or drug use? ☐ Yes ☐ No
II. Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No
III. Have you felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No
IV. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? ☐ Yes ☐ No

☐ Substance is taken in larger amounts or over a longer period of time than intended.

☐ There is a persistent desire or unsuccessful efforts to cut down or control substance use.

☐ A great deal of time is spent in activities necessary to obtain, use, or recover from use.

☐ Experiencing cravings or strong desire to use substance.

☐ Recurrent use resulting in failure to fulfill major role obligations at work, school, or home.

☐ Continued use despite having persistent or recurrent social or interpersonal problems exacerbated by use.

☐ Important social, occupational, or recreational activities are given up due to substance use.

☐ Recurrent use in situations in which it is physically hazardous.

☐ Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely caused or exacerbated by substance use.

☐ Increased tolerance

☐ Experiencing any withdrawal symptoms without use.

Current craving level (1-10)? ______

Are you engaged in any 12 Step programs? ☐ Yes ☐ No

If yes, please explain: ____

Is there any family history of alcohol or drug use/abuse? ☐ Yes ☐ No

If yes, please explain ____

Legal Issues (current or past): ☐ Yes ☐ No

If yes, please explain: ____

____

Motivation level to get/stay sober ☐ High ☐ Moderate ☐ Low ☐ External

Is there anything else you would like us to know? ______________________________

____

____

Acknowledgement

Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge.

____

Individual or Legal Representative Printed Name Date

____

Individual or Legal Representative Signature Date

THANK YOU for taking the time to complete this intake and once again, welcome to the *Caldwell Counseling Center*. I am looking forward to our collaboration together.

Release of Information

I hereby authorize: ☐ Caldwell Counseling Center

To:		
	☐ Release information to:	Name: ______________________________
	☐ Obtain information from:	Contact: ______________________________
	☐ Exchange information with:	Name: ______________________________
	☐ Verbal	Contact: ______________________________
	☐ Written	Name: ______________________________
		Contact: ______________________________

The information requested or authorized for release or exchange pertains to:

- ☐ Mental Health
- ☐ Developmental and/or social history
- ☐ Progress notes and treatment plans and/or summary of treatment
- ☐ Drug or alcohol use/abuse
- ☐ Diagnosis
- ☐ Other:____

This authorization is valid for 90 days from the date below or ___________________, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the counselor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my counselor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

____

Individual or Legal Representative Printed Name Date

____

Individual or Legal Representative Signature Date

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by informing us in writing. This authorization will remain in effect until cancelled.

Credit Card Information				
Card Type:	☐ MasterCard ☐Other	☐VISA	☐ Discover	☐ AMEX
Cardholder Name (as shown on card):				
Card Number:				
Expiration Date (mm/yy)				
CCV (on back of card):				
Cardholder Billing Address:				

I,____, authorize *Caldwell Counseling Center*_ to charge my credit card above for completed session, missed session without 24-hour cancelation notice, or any outstanding bill. $75.00 will be charged for missed sessions without a 24-hour notice.

_____ Recurring Billing: I hereby authorize to *Caldwell Counseling Center* charge the indicated credit card on a periodic basis for the amount due on this client account. This Recurring Payment Authorization / Periodic Charge shall remain in force until cancelled by me in writing. I understand that my information will be saved to file for future transactions on my account.

_____I agree that there will be a Recurring Payment Authorization / Periodic Charge that will be made for services completed, missed without 24-hour cancelation notice, or any outstanding bill as indicated above, and will not dispute the charge in the future. To terminate the recurring billing process, I must cancel in writing. I guarantee and warrant that I am the legal cardholder for this credit card and I certify that all information above is complete and accurate and that I am legally authorized to enter into this recurring billing agreement with *Caldwell Counseling Center.*

____

Individual or Legal Representative Printed Name Date

____

Individual or Legal Representative Signature Date