Compassion Centered Counseling

CONTRACT, OFFICE PROCEDURES, and FINANCIAL AGREEMENT FOR PSYCHOTHERAPY SERVICES

Welcome to Compassion Centered Counseling, PLLC. This document contains important information about Compassion Centered Counseling, PLLC professional services and business policies. We are governed by various laws and regulations and by the code of ethics of our profession. The ethics code requires that we make you aware of specific office policies and how these procedures may affect you. Therefore, we are providing this information in writing. We encourage you to take the time to read through this carefully before your first appointment. Please jot down any questions you might have so that you and your therapist can discuss them at your initial meeting. When you sign this document, it will represent an agreement between you and Compassion Centered Counseling, PLLC.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law.
When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a patient presents a danger to self, to others, to property, or is gravely disabled; abuse of patients in a mental facility; and sexual exploitation.
When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by CCC. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. The CCC counselors will use their clinical judgment when revealing such information. Other situations where the counselor has a duty to disclose, or where, in the counselor's judgement, it is necessary to warn or disclose are in disputes between the therapist and the client; a negligence suit brought by the client against the counselor; or the filing of a complaint with the licensing or certifying board.

Health Insurance & Confidentiality of Records: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that is designed to protect the privacy of patient information, provide for the electronic and physical security of health and patient medical information, and simplify billing and other electronic transactions by standardizing codes and procedures. A piece of this law recently took effect and is known as the HIPAA Privacy Rule. The HIPAA Privacy Rule creates a minimum federal standard for the use and disclosure of Protected Health Information (PHI) by health care organizations. One of the requirements of the Privacy Rule is that we give to you a Notice of Privacy Practices (NPP) that describes your rights and protections regarding your health care records (PHI). The Notice explains your rights regarding your private healthcare information, including your right to:

- Inspect and copy your medical records;
- Request an amendment or addendum to your medical records;
- An accounting of disclosures of your private health information;
- Request restrictions to release your medical information; and
- Request restrictions of confidential communications with you.

This document is included as part of the **website forms** that you can review and/or print out as you wish prior to your initial appointment. Upon request, paper copies may also be obtained in the office. By signing this contract, you are consenting to a release of information about your case to your health plan for claims, to the billing services, to certification and case management for the purposes of treatment and payment. CCC has no control or knowledge over what insurance companies do with the information that is submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance.

I have reviewed and understand CCC's HIPAA policies- Notice of Privacy Practices and have been made aware of how my records may be used and disclosed.

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Signature of Client/Responsible Party　　　　Print Name　　　　Date

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Additional Client Signature (Spouse, /Partner, Family Member)　　　　Print Name　　　　Date

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TELEPHONE & EMERGENCY PROCEDURES:

- The phone number for the office is **(817) 666-3067**. If you receive the voice mail, please leave a message for your counselor. Your counselor may be on the phone, in therapy with someone else, or out of the office.
- In a crisis, if your therapist cannot be reached and you are in imminent danger **call (911), or go immediately to your local emergency hospital. You can also contact the Tarrant County Hotline at (817) 335-3022; available 24 hours a day (free).**
- If you need to contact CCC between sessions, for an emergency, please indicate it clearly in your message. Telephone calls are monitored during the day as time allows and therefore, we cannot guarantee immediate return calls. CCC counselors are not responsible for your behaviors or decisions occurring outside the consultation room, whether before or after a telephone call or consultation.
- If there is an emergency whereby an CCC counselor becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, the counselor will do whatever he/she can within the limits of the law, to prevent you from injuring yourself or others; and to ensure that you receive the proper medical care. For this purpose, the counselor may also contact the person whose name you have provided as an **Emergency Contact** on the Intake Form.

INFORMED CONSENT FOR TELEPHONE, ELECTRONIC, AND MAIL CONTACT: Ordinary privacy precautions are by no means foolproof, and your confidentiality is always compromised when communicating by electronic devices or mail. Nor is deletion or shredding of private material a totally safe means of disposal, and you are always at risk of breaches in confidentiality when electronic or mail communication of any type is used for private information. Your use of such means of communication with CCC constitutes implied consent for reciprocal use of electronic and mail communication as well. By signing this contract, you agree to and understand the following:

- Many people feel comfortable communicating via email, because they have installed programs designed to detect spy ware, viruses, or other dangerous software. However, there is no guarantee that such programs will work 100%.
- Sent and received emails are stored on both CCC and your computer until deleted. CCC may or may not delete such emails. Any saved emails will be kept in a password-protected account that only CCC has access to.
- In addition, whenever you send an email, it is stored in cyberspace. It is possible for authorities to locate and read such emails under various circumstances, this is not a policy of CCC, but is due to the nature in which email is transmitted using the Internet, and other services or networks.
- Email/written communication with a CCC counselor is preferred through the client portal where there is a reduction in risk.
- By initialing below, I agree that I understand the disclosures listed above regarding communicating with CCC using email. I also agree that if I send an email to a CCC counselor and request a response via email, that I am willing to accept the above stated risks. I also agree that I will not use email for emergencies.

Sign below if you give your permission for CCC to initiate sending emails to you and leave voicemail messages.

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Signature of Client/Responsible Party   Print Name   Date

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Additional Client Signature (Spouse, /Partner, Family Member)   Print Name   Date

CONSENT TO TREATMENT AND CONFIDENTIALITY STATEMENT:

I, (print name of responsible party) ____consent for treatment to be rendered by a therapist of Compassion Centered Counseling. I grant the therapist to perform those procedures and treatments, which may include professional consultation or emergency telephone responses, necessary for my condition that are generally used in this and similar settings. I understand that information or opinions will be given to others only with my written consent.

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Signature of Client/Responsible Party   Print Name   Date

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Additional Client Signature (Spouse, /Partner, Family Member)   Print Name   Date

Compassion Centered Counseling

APPOINTMENTS: All office visits are by appointment and may be scheduled through the client portal online or your counselor directly. Because consistency is an important part of the counseling process, the appointment time you schedule is reserved for you and is not available to anyone else. Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 50 minutes and another 3-5 minutes to reschedule if needed. If you are unable to keep a scheduled appointment, you must notify CCC **at least 24 hours in advance** to avoid having to pay for a **late canceled or missed appointment**. Please leave a message if you get the voice mail.

CANCELLATION POLICY: It is our policy to charge a **$65.00 fee** for appointments that are not cancelled at least 24 hours in advance. If our office is closed, you may leave notice of cancellation on the voicemail or email your counselor, which will note the day and time you called. For Monday appointments, a cancellation can be left on voicemail or email over the weekend 24 hours in advance. Appointment scheduling, rescheduling, or cancelling is also available through the online client portal. You may cancel in the online portal at least 24 hours in advance and not be charged the late fee. Your communication about appointment cancellations allows us to offer that time to someone else who needs to be seen. We appreciate your cooperation with this.

PAYMENT & INSURANCE REIMBURSEMENT:

- Clients paying on a cash basis, and not billing any insurance company are expected to pay in full at time of service unless other arrangements have been made.
- Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable.
- Insured clients are expected to take care of their fees as services are rendered. Your health insurance may help you recover some of your counseling costs. Most group policies, but few individual policies cover outpatient psychotherapy. Please verify with your company the amounts of coverage for outpatient psychotherapy. If your policy requires preauthorization to receive services, this is your responsibility and needs to be handled before your first visit.
- Our office will bill your insurance company for services provided. You will receive a statement each month reflecting any balance due on your account. You are responsible for payment, deductible, and insurance claims on your account.
- Clients are personally responsible for all payment of fees, including those not paid by their insurance carrier within 30 days after the rendering of services.
- The client portion (co-pay) of fees is expected at the time of service. Co-pays are not negotiable. Failure to pay your part may jeopardize your benefits.
- Additional fees are charged for lengthy telephone communications, court attendance and report/letter writing. Insurance does not cover this.
- Professional Fees: Court appearances, depositions, and attorney consultations are $140.00 per hour (including all time involved in preparation, research, parking fees, mileage, travel time to and from the court house and all other expenses incurred in relation to testifying). A retainer deposit of $1400.00 is to be paid in advance of prior to the court date. If the full amount of the retainer/deposit is not needed to complete the court testifying process, then the remainder of the funds will be refunded to you. If the costs for the court testifying process exceed the amount of the retainer/deposit then those fees will be immediately billed to you and are due upon receipt of the invoice. The party issuing the subpoena is responsible for the testifying fees. (*Note: Even though you are responsible for the testimony fee, it does not mean that the testimony will be solely in your favor. Only the facts of the cases and professional opinion of your counselor can be testified).*
- There is a $25.00 service fee for checks returned for non-sufficient funds, and the client will be required to pay for future sessions in cash. Before any future visits occur, the client or responsible party must pay in cash the service charge PLUS the value of the check.
- At any time during treatment should the client become ineligible for insurance coverage, the client and/or responsible party agrees to notify the counselor and will be responsible for 100% of the bill.

ASSIGNMENT OF BENEFITS: I authorize all insurance payments to be made to the designated provider of Compassion Centered Counseling. This assignment will remain in effect until revoked by me in writing. I understand that this order does not relieve me of my obligation to pay such bills if not paid by my insurance company, or any balance due after payments by my insurance company. It is the client's responsibility to provide our office with the correct insurance information in order to file claims with the insurance company. Claims not paid due to incorrect information will then become the client's responsibility.

If you are more than 15 minutes late for your appointment, you will be responsible for the $65.00 fee for the session, which is not reimbursable by insurance.

I understand that I am financially responsible to Compassion Centered Counseling for the charges incurred by myself and/or my dependents. ***(If you are not filing insurance you do not have to sign this segment).***

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Signature of Client/Responsible Party Print Name Date

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Additional Client Signature (Spouse, /Partner, Family Member) Print Name Date

PROFESSIONAL RECORDS: The laws and standards of the profession require that CCC keep treatment records. You are entitled to receive a copy of your records, or your therapist can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, we recommend that you review them in the presence of your counselor so that she/he can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

GRIEVANCES: I also acknowledge that I may submit a Grievance to the Provider at any time to register a complaint about any aspect of my care. If I am not satisfied with the responses I receive, I may submit the Grievance to the address below:

- **To report a rules violation by this licensee, contact the appropriate Board: Texas State Board of Examiners of Licensed Professional Counselors**
- **At the following address: P.O. Box 141369, Austin, TX 78714-1369 OR (1-800-942-5540)**

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Signature of Client/Responsible Party Print Name Date

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Additional Client Signature (Spouse, /Partner, Family Member) Print Name Date

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES:
I understand I have a right to review Compassion Centered Counseling (henceforth referred to as **CCC**) Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (henceforth referred to as **PHI**) that will occur in my treatment, payment of bills and the rights I have regarding my **PHI**. I consent to the use of disclosure of my **PHI** for these purposes.

I understand I have the right to request a restriction as to how my **PHI** is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **CCC** is not required to agree to the restrictions that I may request. However, if **CCC** agrees to a restriction that I request, the restriction is binding on **CCC** and my counselor. I also understand that if these restrictions limit the ability of my insurance to pay, I will be held responsible for the entire fee up front.

I have the right to revoke this consent, in writing, at any time, except to the extent that my counselor or **CCC** has already taken action based on this consent.

The Notice of Privacy for **CCC** is provided upon request. **CCC** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or by requesting one at the time of an appointment.

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Signature of Client/Responsible Party Print Name Date

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Additional Client Signature (Spouse, /Partner, Family Member) Print Name Date