AGREEMENT FOR COUNSELING SERVICES AND CONSENT FOR TREATMENT

Thank you for choosing me for your counseling needs. I am committed to giving you the best care possible. To acquaint you further with my professional services and business policies, I am providing the following information:

Appointments: Appointments are made with me at the end of a therapy session, or by phone at 972-473-0501. Therapy sessions are 45-55 minutes in length. The number and frequency of sessions needed depends on many factors and will be discussed after our initial meeting.

CANCELLATION POLICY: There will be a $50.00 fee for cancellations made less than 24 hours in advance of a scheduled appointments.

Contacting Me: Due to my work schedule, I am not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail. I will make an effort to return your call in a timely manner, that same day or the next. In the case of an emergency however, contact your family physician or the nearest emergency room and ask for the psychiatrist on call.

Email Communications:
I can receive brief email communications related to appointments and specific brief informational exchanges, however, I do not perform therapeutic services via email or respond to therapy related topics outside of our therapy appointment times. My business email account is not checked outside of my normal business hours or on weekends with only minor exceptions and should not be utilized or relied upon to communicate any therapy related issues for that reason.

Phone Sessions: Phone sessions are generally conducted during normal business hours and are limited to situations where an existing client has an extended out of town situation. Phone sessions are treated the same as regular therapy sessions in terms of time duration and billing. To the extent phone sessions are not covered by your insurance plan, my standard hourly rate will be applied and it will be your financial responsibility.

Financial Responsibility: You are fully responsible for all services rendered. Full payment is expected at time of service, unless other arrangements are made in advance. My regular fee is $130.00 for a 55 minute session and $260.00 for a double session (100 minutes). If your insurance plan limits our sessions to only 45 minutes, then the session will be limited to 45 minutes. Payment options include cash, check or credit card. There will be a $25.00 fee for payments returned as insufficient funds. If an account becomes significantly past due you will be notified by mail or email at the address listed on your contact information.

Confidentiality: The Health Insurance Portability and Accountability Act (HIPPAA), is 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. The law protects the privacy of communications between a patient and counselor. Everything about your care will be held in the strictest confidence. In most situations, I can only release information about your treatment to others with your written consent. Possible exceptions to confidentiality include, but are not limited to the following situations: Suspected or reported child abuse or abuse to elderly or disabled persons; imminent/serious threat of injury by you to yourself or others; court ordered legal proceedings. If you have any questions or concerns about confidentiality, it is important that you bring them to my attention in order that we may discuss them further.

In addition, it is important for you to know that our relationship will be a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that I not have any other relationship with you. Personal and/or business relationships can undermine the effectiveness of the therapeutic relationship and are not permissible by the Texas State Board of Licensed Professional Counselors.

Court Appearances Testimony or Depositions or Responses to Depositions, or reports for employers or the court : I do not provide professional expert witness services in my practice. In the event that I am required to provide records, testimony, or depositions you will be charged for all preparation, travel, and court time at my standard bill rates in force at that time. In the event any type of special report or assessment is required, by the court system or an employer, I will generally refer you to other professionals, and will charge you for any assessment consultation required of me by that professional.

Insurance Reimbursement: For non-contracted insurance plans, you are required to make payment in full at the time of service and you may bill your insurance directly, with the completed fee ticket you receive. For **contracted** insurance plans, **please verify your benefits and record this information on the Insurance Verification Form** (provided on the website) and bring to the first visit. You are responsible for the co-payment, deductible and non-covered services as determined by your contracted insurance plan for reimbursement. You are responsible for notifying me immediately of any change in your insurance plan or coverage. **Insurance company-quoted benefits are not a guarantee of payment.**

You should be aware that our contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release

only the minimum information about you that is necessary for the purpose requested. Contact your insurance carrier if you have questions regarding how they handle your personal health information once it is received.

PLEASE SIGN BELOW TO INDICATE YOU HAVE READ AND UNDERSTANT THE ABOVE <u>AGREEMENT FOR SERVICES</u> AND THAT YOU ARE CONSENTING TO RECEIVE TREATMENT FOR CINDY JACKSON, LPC, NCC.
YOU MAY REVOKE THIS AGREEMENT IN WRITING AT ANY TIM

Patient/Guardian Name (PRINT)

_____ _____

Patient/Guardian Signature Date