

Alliance Counseling and Education Center

Professional Disclosure Statement and Informed Consent

PLEASE INITIAL EACH ITEM:

_____ I understand that Kim England is a Licensed Clinical Social Worker in the state of Texas.

_____ I understand that Kim England does not provide 24-hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1 or go to an emergency room for assistance. I understand that if Kim England has to return any crisis calls to me that the call will be billed at a rate of \$3.00 per minute.

_____ I understand that during the time that we work together, we will meet weekly for approximately 45 minutes. While our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one.

_____ I understand that, at any time, I may initiate a discussion of possible positive or negative effects of entering into the counseling relationship and that specific results are not guaranteed although benefits are expected from counseling.

_____ I understand that counseling can improve as well as upset the equilibrium in any person or family. Counseling is a personal exploration and may lead to changes in my life perspectives and decisions. These changes could be temporarily distressing.

_____ I understand that I am in control of the counseling relationship and may choose at any time to end the therapeutic relationship. If at any time I am dissatisfied with Kim England's services as a therapist, I have a right to let her know. If I do not feel that Kim England may resolve my complaint, I may file a formal complaint through contact with the Texas Board of Social Work Examiners by mail at Complaints Management and Investigative Section, P.O. Box 141369, Austin, TX 78714-1369.

_____ I understand that our paths may cross in social situations but that our therapeutic relationship comes first, along with protections of my confidentiality, and that Kim England does not initiate greetings.

_____ Should I believe that a referral is needed, Kim England will provide some alternatives including programs and/or people who may be able to assist me.

_____ I understand that the rate for individual counseling sessions is \$125.00 for the initial session and \$100.00 for a 45-minute session.

_____ I understand that Kim England will not tolerate any perceived threat to her personal safety and Kim England is capable of terminating the counseling relationship if such a situation should arise.

_____ I understand that the rate for couples and family counseling is \$125.00 for the initial session and \$100.00 for a 45-minute session.

_____ I understand that all fees for counseling are due prior to, or at the time of each session. If I am late for an appointment, I must still pay for the full session.

_____ I understand that the rate for all subsequent therapy services such as: attending parent/teacher conferences, attending ARD meetings, conducting classroom observations, participating in legal depositions, interactions with insurance companies, consultations with attorneys, etc. will be billed at \$100.00 per hour in 15-minute increments.

_____ I understand that should I subpoena Kim England as a factual case witness or involve her in any court-related processes, Kim England charges a retainer fee of \$1000.00 with an additional \$100.00 each hour she is involved in legal dispositions, case preparation, travel, and witness time. The party issuing the subpoena is responsible for the fee. Even though you are responsible for the testimony fee, it does not mean that Kim England's testimony will be solely in your favor. Kim England can only testify to the facts of the case and to her professional opinion.

_____ I understand that if I do issue Kim England a subpoena without her approval (see above) that my subpoena will be directly turned over to her attorney and a bill will be rendered to me for immediate retainer fee payment.

_____ I understand that if a check is returned, a processing fee of \$25.00 will be assessed to my account. Additionally, I will need to make a cash or money order payment for the returned check and \$25.00 processing fee. After a returned check, the office of Kim England may require cash payment of future appointments.

_____ I understand that if a returned check is not cleared up in 30 days, Kim England will file a suit with the local County Districts Attorney's Office.

_____ I understand that I am responsible for any appointments that are not cancelled at least 24 hours (Monday through Friday excluding holidays) prior to my appointment time, with the EXCEPTION OF AN EMERGENCY.

_____ I understand that if I do not cancel my appointment 24 hours (Monday through Friday excluding holidays) ahead of time, the fee for calling to cancel on the day of my appointment is \$50.00.

_____ I understand that not showing up for an appointment will result in my being charged \$100.00 for the missed session.

_____ I understand that Kim England **DOES NOT** allow recording of any kind, including hand-held tape recording, video recording, or cellular phone recording during counseling sessions or telephone conversations without prior written consent.

_____ I understand that my records and all of our communications become part of the clinical record. Records are the property of Kim England. Adult client records are disposed of seven (7) years after the client has stopped receiving services. **It is Kim England's policy to not release clinical records.**

_____ I understand that while most of our communication is confidential there are however, circumstances when disclosures can occur without my prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

- You are a danger to yourself or someone else.
- In situations of suspected child, spouse, or elder abuse, it is the duty of the mental health provider to notify medical, legal, or other authorities.
- You disclose sexual contact with another mental health professional.
- If you are involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
- Kim England is ordered by a court to disclose information.
- You direct Kim England in writing to release your records.
- If Kim England receives consultation in order to provide you with the best quality care.
- Kim England is otherwise required by law to disclose information.

Mental Status Information

Have you or your spouse/significant other ever attempted suicide or harmed yourself in any way? Yes No

Are you or your spouse/significant other currently thinking about suicide or harming yourself in any way? Yes No

Have you or your spouse/significant other had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way? Yes No

Are you or your spouse/significant other having any thoughts about harming anyone else in any way? Yes No

Statement of Understanding

I have read the above and understand the nature of service provided and the limits of confidentiality outlined above and I solemnly swear that all of the above information is true to the best of my knowledge.

Client Signature

Date

Agreement for Therapy

I, _____

- Agree to receive therapeutic services provided by Kim England, LCSW.
- I have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both myself and my family.
- Furthermore, I understand that I am expected to be an active participant in this process.
- I acknowledge that I have received and understand the notice of privacy practices for this office.
- My signature below means that I understand and agree with all of the points above.

Client Signature

Date

Health Provider's Statement

I have inquired to insure that the patient understood the above description of the limits of confidentiality.

Health Provider's Signature

Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice is effective 01/01/2012

This notice of Privacy Practices describes how Kim England may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including

demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, or our protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

Healthcare Operations: Kim England may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapist associated with this practice, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to graduate students who see clients at our office. In addition, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information in the following situations without your authorizations: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

Other permitted and required uses and disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I acknowledge that I have received and understood the HIPPA Notice of Privacy Practices for this office:

Client Signature (parent or guardian if minor patient)

Date

I hereby permit and release Kim England to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare

operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

Client's Name

Client's Date of Birth

Client signature (parent or guardian if minor patient)

Relationship

Client printed name (parent or guardian if minor patient)

Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance to this consent. Your treatment by this office is conditional on your signing this consent.