Journeys Counseling Center
6500 Quaker Ave, Ste D
Lubbock, TX 79413
806-687-5413
806-317-1588
office@journeyscc.org
www.journeyscc.org

Informed Consent

Welcome to Journeys Counseling Center. Since this is your first visit, we hope what is written here can answer some of your questions as you seek therapy. Please let us know if you want clarification on any of the topics discussed in this Outpatient Services Contract, or if you have any questions that are not addressed here. When you sign this document, you are stating that you understand and will adhere to the information in this Outpatient Services Contract.

PSYCHOTHERAPY SERVICES

We provide psychotherapy services for children, adolescents, adults, couples and families. The first appointment(s) serves as an intake appointment. We will want to hear about the difficulties that led to you making an appointment, goals for therapy, and general information about yourself and your current life situation. By the end of this first appointment, we will give you some initial recommendations on what we think will help. If we do not think we are able to best assist you, we will give you names of other professionals who we believe would work well with your particular issues. If you do not agree with our treatment recommendations or do not think our personality styles will be a good match for you, let us know and we will do our best to suggest a different therapist who may be a better fit.

If you and your therapist decide to work together in therapy, you will collaborate on a treatment plan that incorporates effective strategies to help with whatever difficulties you are hoping to reduce in therapy. Sometimes more than one approach is helpful. Individual, couples and family therapy sessions last 45-60 minutes (depending on your insurance benefits) unless otherwise arranged. Oftentimes, sessions are set for once each week, but this varies based on what seems most appropriate for your particular situation.

Therapy can be extremely helpful and fulfilling, and it takes work both in and out of sessions to be most effective. It requires active involvement, honesty, and openness in order to change thoughts, emotional reactions and/or behaviors. There are benefits and risks to therapy. Potential benefits include increased healthy habits, improved communication and stability in relationships, and lessening of distress. Some potential risks include increased uncomfortable emotions as you self-explore, and changes in dynamics or communication with significant people in your life. Sometimes couples that come for therapy choose to end their relationships. Although there are many benefits to therapy, there is no guarantee of positive or intended results. If during your work together with your therapist, noncompliance with treatment recommendations becomes an issue, we will make effort to discuss this with you to determine the barriers to treatment compliance. At times, treatment noncompliance may necessitate termination of therapy service. We encourage you to discuss any concerns you have about our work together directly so that we can address it in a timely manner. Other factors that may result in termination of therapy include, but are not limited to, violence or threats toward us, or refusal to pay for services after a reasonable time and attempts to resolve the issue.

Deciding when therapy is complete is meant to be a mutual decision, and we will discuss how to know when therapy is nearing completion. Sometimes people begin to schedule less frequently to gradually end therapy. Others feel ready to end therapy without a phasing out period of time. We may at times seek consultation with other therapists to ensure we are helping you in the most effective manner. We will give information only to the extent necessary, and we make every effort to avoid revealing the identity of my clients. The consultant is also under a legal and ethical duty to keep the information confidential.

AVAILABILITY BETWEEN SESSIONS

If needed, you can contact your therapist directly by text, call or email. When you leave a message, include your telephone number even if you think we already have it, and best times to reach you. We make every effort to

return calls in a timely manner. In the rare occurrence that a message is missed or accidentally deleted, if you do not hear back from us within one day, please leave a second message. Please note that we are not available outside of our normal business hours and hours vary for each therapist. If we are unavailable for an extended time, such as on vacation, we will inform you of the contact information for the therapist on-call during our absence.

If you are in an emergency situation and cannot wait for us to return your call, go to the nearest emergency room or call 911. Journeys Counseling Center is not a crisis facility. Do not contact us by text, email or fax in an emergency, as we may not get the information quickly.

Please note that any contact with your counselor outside of sessions is subject to out of pocket fees. Only communication about scheduling is not billed between sessions. If you contact your therapist about any other issues, the credit card on file will be billed for time spent on that issue. Insurance does not cover this type of service.
Out of pocket contact fees are billed in 15-minute increments at $25 per 15 minutes. The counselor determines the amount of time spent on each issue and the card on file will be billed the day the service is provided.

RATES AND INSURANCE

Therapy is a commitment of time, energy and financial resources. If you have health insurance, it is important for you to verify your mental health benefits so you understand your coverage prior to your appointment. Some insurance companies require a precertification before the first appointment or they will not cover the cost of services.

Our current fees are as follows:

- Initial Intake Appointment: $120.00
- Counseling Sessions: $100.00
- Patients with insurance: the negotiated rate with each insurance company

These fees are reviewed annually and an increase of $5 per year applies to our rates every January 1st.

We also provide telephone and online therapy sessions. Some health insurance carriers cover telehealth (telephone/online therapy). If your insurance plan does not cover teletherapy, it is your responsibility to pay our full rate per session.

We are happy to assist you by having our Practice Manager file claims to your insurance company on your behalf. However, you, not your insurance company, are responsible for payment of the fee for therapy. Acceptable forms of payment include cash, check and major credit cards, and payment is expected at the time of service. **Cancellations or missed appointments without 24 hours notice will be subject to full fee charge, and insurance companies do not pay charges for missed appointments.** If fees for services are not paid in a reasonable amount of time, and attempts have been made to resolve the financial matter to no avail, a client account may be sent to a collection service. In addition, we do not bill secondary insurance.

We check insurance benefits as a courtesy for our clients. There are times when insurance misquotes benefits. In the event of a misquote, clients are still responsible for their copay/coinsurance/deductible amount that insurance reports after claims are submitted. Clients can call their insurance company to check their own benefits as well by calling the number on the back of their insurance card.

Most insurance agreements require you to authorize us to provide a clinical diagnosis and sometimes additional clinical information. If you request it, we will provide you with information to send to your insurance company. This information will become part of the insurance company's files. Insurance companies claim to keep

information confidential, but you should check with your insurance company directly if you have questions about their confidentiality practices.

MISSED APPOINTMENT POLICY

Please be aware that your scheduled time is set-aside solely for you. If are unable to make your scheduled time, please notify our office in at least 24 hours prior to the start time.
You are allowed 2 cancellations in a 6-month time period. After 2 cancelled/missed appointments, you might be terminated and referred to a new office. You are not billed for the first missed appointment, but **you are billed for the 2nd and any ongoing missed appointments.** The credit card on file will be charged at the time of the missed appointment. Amount billed will depend on insurance/cash prices and vary for each client. Please ask for your specific amounts if you would like that information.

SICK POLICY

We have many clients of all ages in the office daily. Please do not come to the office or bring anyone with you to the office who is current sick. This includes anything that is contagious. If you have not been on medication for 24 hours, we ask that you reschedule your appointment. If you attend a session while sick, you might be asked to leave in order to ensure the health of our therapists and other clients.

SOCIAL MEDIA POLICY

In order to maintain your confidentiality and our respective privacy, we do not interact with current or former clients on social networking websites. We do not accept friend or contact requests from current of former clients on any social networking sites including Twitter, Facebook, LinkedIn, etc. We will not respond to friend requests or messages through these sites.

We will not solicit testimonials, ratings or grades from clients on websites or through any means. We will not respond to testimonials, ratings or grades on websites, whether positive or negative, in order to maintain your confidentiality. Our hope is that you will bring concerns about our work together to the therapy session so we can address concerns directly.

Please do not contact us through text messages regarding clinical issues. Texts are not a secure communication, and there is possibility that we will not get the message in a timely manner, or that communication will be interpreted in an unclear manner. If you need to contact your therapist between sessions, please contact them directly. Text messages are only to be used for scheduling, changing or canceling appointments.

PROFESSIONAL RECORDS

Both law and the standards of our profession require that we keep appropriate treatment records. If we receive a request for information about you, you must authorize in writing that you agree that the requested information released.

CONFIDENTIALITY

In general, law protects the confidentiality of all communications between a client and a mental health clinician, and we can only release information to others with your written permission. However, there are a number of exceptions, which are have indicated below. More information is provided about this in your HIPAA statement.

In judicial proceedings, if a judge orders the records released, we have to release the records. In addition, we are ethically and legally required to take action to protect others from harm even if taking this action means we reveal

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information about you. For example, if we believe a child, elderly person or disabled person is being abused or neglected, we are mandated to report this to the appropriate state agency. If we believe a client is threatening serious harm to another person or property, we must take protective action (through notifying the potential victim, the police, and/or facilitating hospitalization of my client). If we believe a client is a serious threat to harming him/ herself, we must take protective action (arranging hospitalization, contacting family/ significant others for notification, and/ or contacting the police). We would make reasonable effort to discuss any need to disclose confidential information about you, and we are happy to answer any questions you have about the exceptions to confidentiality.

RECORDING

Absolutely no recording is allowed in this office. If we suspect you are recording, we will end your appointment immediately. We then reserve the right to terminate counseling totally or ask that you do not bring any items into the office during your sessions.

MINORS

If you are under 18 years of age, please be aware that Texas law provides your parents/managing conservator/guardian the right to examine your treatment records. Your parents are entitled to the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Before giving them any information, your therapist will discuss the matter with you, if possible, and do their best to handle any objections you may have with what is prepared to discuss. You can be offered counseling without parental/guardian consent if you meet any of the following circumstances: 1. You are on active duty in the armed forces 2. You are 16 years of age or older and reside apart from parents/conservators/guardians AND manage your own financial affairs (regardless of the source of income) 3. You are thinking about suicide 4. You have concerns about alcohol and/or drug addiction or dependency 5. You have been sexually, physical or emotionally abused.

SEPARATION/DIVORCE

You agree to provide legal documentation regarding conservatorship and your legal rights to consent to treatment for your child. If parents share joint managing conservatorship, both parents must consent to treatment. If one parent is not currently involved with the child but has joint conservatorship, we are required to contact the parent to receive consent for counseling services. If a parent does not live locally and wants to participate in counseling services, they may be billed for those services, which might not be covered by insurance.
Our office does not separate payments. We will bill one parent for all services and parents are responsible for balancing the bill outside of counseling. You can request a monthly bill to assist with this.
We will provide treatment that will help facilitate your child's adjustment to the separation or divorce, but we do not serve as expert witnesses or provide testimonial services in custody battles.

COURT RELATED SERVICES

We do not provide or perform evaluations for custody, visitation or other forensic matters. Therefore, it is understood and agreed that we cannot and will not provide any testimony or reports regarding issues of custody, visitation or fitness of a parent in any legal matters or administrative proceedings.

If we are contacted by an attorney regarding your treatment (either at your behest or related to a legal matter you are involved in) please note the following:

- We charge a $1000 retainer prior to any preparation or attendance of legal proceedings.
- We charge $150/hour to prepare for and/or attend any legal proceeding and for all court related services.

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- If a subpoena is cancelled less then 48 hours prior, the full amount for preparation will still be billed plus 4 hours for time planned for court.
- Charges for court related services are not covered by insurance.
- Court related services include: talking with attorneys, preparing documents, traveling to court, depositions and court appearances.
- If the court or attorneys do not pay our fee, you will be charged for the time we spend responding to legal matters
- You will also be charged for any costs we incur responding to attorneys in your case, including but not limited to fees we are charged for legal consultation and representation by our attorneys.
- Please be aware that in the event that the requested services is not beneficial to you and does not positively assist your legal case, you are still required to pay for the services. Payment of services does not ensure that legal issues resolve in your favor.
- All fees are doubled if therapist has plans to be out of the office on or around the requested court day.

COMPLAINTS

If you have a concern or complaint about your treatment or about your billing statement, please talk to us about it. We will take your criticism seriously, openly, and respond respectfully.

QUESTIONS

If during the course of your therapy, you have any questions about the nature of your therapy or about your billing statement, please ask.

A FINAL WORD

The counseling relationship is a very personal and individualized partnership. We want to know what you find helpful and what, if anything, may be getting in the way. We want you to feel free to share with us what we can do to help.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

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If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

- **Treat you**

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

- **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

- **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

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We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Please keep pages 1-8 for your record. Complete and turn in pages 9-12. If completing online, you can email the forms to office@journeyscc.org

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Outpatient Services Contract

Please ask before signing below if you have any questions about psychotherapy or our office policies. Your signature indicates that you have read our Outpatient Services Contract and agree to enter therapy under these conditions. Your signature below indicates that you are making an informed choice to consent to therapy and understand and accept the terms of this agreement.

I have read and agree to the terms in the outpatient services contract (pages 1-5).

Client Name: _____

Client Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Notice of Privacy Practices

I have read the notice of privacy section (pages 6-9).

Client Name: _____

Client Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

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Please complete all parts of this page.

Demographic Information

Date _____

CLIENT _____
First Name Initial
Last Name

Street Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Birthdate: _____ Gender _____ Marital Status: _____

Home: _____ Cell: _____

Can messages be left at these numbers? ( ) Yes ( ) No

Can text messages be sent at these numbers? ( ) Yes ( ) No

Email Address: _____

Preferred method to receive appointment reminders: EMAIL TEXT PHONE CALL

Emergency Contact Information:

Name: _____ Relationship _____

Address: _____ Phone Number: _____

Additional Information:

What are your presenting issues? _____

How were you referred to Journeys:_____

Please list any medical conditions and/or allergies (client): _____

Please list any prescription medication/doses: _____

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AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, ALCOHOL & DRUG ABUSE, AND OTHER PERSONAL HEALTH INFORMATION

I, _____ hereby authorize___***Journeys Counseling Center*** _____
(Patient/Parent/Guardian/Power of Attorney) (Facility/Therapist/Counselor)

to exchange/release any and all records or information regarding _____
(Name of Patient)

The following items must be **checked and initialed** to be included in the use and/or disclosure of other health information:

☐ Mental health information ☐ Psychotherapy notes ☐ Drug/alcohol diagnosis, treatment/referral

to _____
(receiving Agency/person) (Address)

for the purpose of (please check all that apply):

☐ Continuing (health and mental health) treatment or care and continuity of care ☐ Therapist transition

☐ Billing, payment and financial matters and arrangements ☐ Consultation, advise and representation

☐ Housing or other arrangements and services ☐ Other _____

This consent is valid until (calendar date)_____

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclosed it without my written authorization.

I also understand that if I refuse to consent to this release of information the following may occur _____

_____ _____
(Minor recipient) (Signature of adult patient or parent)

_____
(Witness)

NOTICE TO PATIENT AND RECEIVING AGENCY:

Under the provisions of the Texas HealthCare Privacy Law, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

REVOCATION OF AUTHORIZATION

The undersigned hereby revokes the above authorization for disclosure.

_____ _____
(Patient, parent, guardian) (Witness)

_____ _____
(Authorized agent - Power of attorney attached) (Date)

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CREDIT CARD ON FILE

Payments are due at the time of service. For your convenience, you may keep a credit card on file with Journeys in order to pay for any copays, co-insurance, deductibles, no shows/late cancellations or out of pocket expenses that accrue in the previous month. Payment is due at the time of your appointment. Your credit card will be stored in a HIPAA compliant electronic health system and this document will be safely destroyed.

Please check the box and sign below:

____ I authorize you to charge my card within 5 business days of my appointment.

Client name: _____

Card Holder Name: _____

Credit Card Number: _____

Expiration Date: _____ Billing Zip Code of Credit Card: _____

Security Code (3 digits on back of card, 4 digits on front if AmEx): _____

Card Holder's Signature: _____
Date: _____

I understand that by signing above, I am authorizing Journeys to charge my card in the manner indicated by my initials above. These balances may include co-pays, co-insurance amounts, out of pocket payments, deductibles, no show or late cancel fees. I understand that I can request for Journeys to mail me a printed statement as proof of payment.