Life Balance Therapy, LLC
Ph. 210-549-MOOD • Fax: 210-610-8291

CLINICAL INFORMED CONSENT for ADULTS

ASSESSMENT AND TREATMENT CONTRACT

Please read this document carefully. Once you have read the document please return to the front desk as an electronic signature will be required from you. If you have any questions with regards to this document, your counselor will discuss them with you individually.

I am voluntarily consenting to allow the Licensed Professional Counselor, Licensed Clinical Social Worker or Licensed Clinical Psychologist at LBT to provide counseling services, psychological assessment and/or psychological treatment for myself.

I will be informed about the nature of the psychological assessment and/or treatment services that will be recommended. I will have the opportunity to discuss concerns. I will help in developing a treatment plan, if necessary. I may stop my assessment or treatment services at any time and have an explanation provided regarding the possible consequences of my decision. Successful termination of services is determined when the counselor indicated above and I agree that the treatment goals are substantially completed.

I understand that there are fees for professional services and that these fees have been discussed with me. **I, OR MY LEGAL GUARDIAN, ACCEPT RESPONSIBILITY FOR THE CHARGES INCURRED.** Payment is due at time of services unless arrangements have been made. If my insurance does not cover the cost of the therapy, I will be responsible for the full balance.

I authorize the counselor or office representative to communicate with my insurance company about my coverage. I authorize the release of billing information to my insurance company concerning provided services and to forward statement of charges to my home (or alternative address if desired).

After hours telephone calls may be accepted. For telephone consultations that require more than fifteen minutes, our office charges **$25** for each fifteen-minute increment or any part of a fifteen-minute increment. Both of these fees are due and payable when they are incurred, but must be paid by the time of your next scheduled visit; insurance does not ordinarily pay for telephone consultations. There may be times when you want your counselor to read documents that will help with understanding you.

FEES FOR SERVICES

Individual Psychotherapy with Master's Level Counselor $100.00
Individual Psychotherapy with Doctoral Level Counselor $120.00
Couples Psychotherapy $120.00
Family Psychotherapy $130.00
Psychological Evaluation (per hour).. $150.00

Your insurance may not cover all of the testing that you are requesting, therefore additional fees may be charged separately. A private pay agreement form will be signed for this separate testing service. The testing fees are typically $150 per hour and increase in price for forensic matters.

I understand that I have certain rights which include the following:

1. All civil rights as guaranteed by Texas and United States Law.
2. The right to be treated with dignity and respect without abuse or neglect.
3. The right to an investigation of a complaint. Every reasonable effort will be made to resolve disputes. The Texas State Board of Examiners of Professional Counselors phone number is: 512-834-6658, Texas State Board of Examiners of Psychologists phone number is: (512) 305-7700. These agencies work to protect the public from unethical professional behavior which violates the rules of practice for providers of mental health services.
4. Limited confidentiality. Confidentiality is honored in most circumstances. However, I am aware that there are many conditions under which confidential information may be legally revealed. The possible limits to confidentiality include, but are not limited to, circumstances where either others, or myself are at imminent risk for serious injury or death, physical or sexual abuse of a minor, court order, or referral for criminal court evaluations.
5. To permit information to be released with a signed authorization indicating what information will be released, for what reasons and to what party.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

This Service Agreement and the accompanying Notice form contain summary information about the Health Insurance Portability and Accountability act (HIPAA), a federal law that provides new privacy protections and new rights for patients with regard to the use and disclosure of your Protected Health Information(PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this consent for treatment forms, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is important that you read them carefully before our session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it, such as, if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Notice of Privacy Practices

In general, state law protects the confidentiality of all communication between a patient and a counselor, and I can only release information about patients with written permission of the individual or parent. I will ask you

to execute a Release of Information form if you desire information about yourself to be released. This release is in force for a period of 90 days but may be rescinded by you at any time. Additionally, if I require information from other caregivers, I will ask you to execute a similar Release of Information so that they may send those records to me.

Here are some exceptions to the confidentiality rule, as I understand them:
In some judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances such as child custody matters and proceedings in which your emotional condition is an important element, a judge may require my testimony if he/she determines that resolution of the issues before the court demands it or you may be required to waive those rights to proceed in those matters.

LIMITS OF CONFIDENTIALITY

There are some situations in which I am legally required to take action to protect others from harm, even though it requires revealing some information about a patient's treatment. If I believe a child, and elderly person, or a disabled person is being abused, I must file a report with the appropriate state agency. If I believe a patient is threatening serious bodily harm to another, I am required to take protective action, which may include notifying the potential victim, the police, or seeking appropriate hospitalization. If a patient threatens to harm him/herself, I may be required to seek hospitalization for the patient, or to contact family members or others who may help provide protection for them. These situations have rarely arisen in my practice. Should such a situation occur, I would make every effort to fully discuss it with you before taking any action, if that is possible.

I may occasionally find it helpful to consult about the case with another professional care provider; this is entirely for our benefit. In these consultations, I will not reveal your identity. The consultant is, of course, also legally bound to keep the information confidential. At other times, I may request that we seek a second opinion, or determine that you require or would benefit from the services of another therapist, or would benefit form services of a psychiatrist or other medical care provider. In all of these situations, I will discuss these matters with you in advance of any action on my part, and obtain your permission prior to facilitating your referral.

Texas Law provides the following instances, where a counselor can disclose confidential information to others. These are as follow:

6. In disputes involving payment or the collection of fees for mental health services
7. To other health care professionals involved in the diagnosis, examination or treatment of the client
8. As needed for licensing or accreditation requirements
9. A judicial proceeding affecting the parent child relationship
10. A criminal proceeding as provided by law
11. In a judicial or administrative proceeding where the court or agency has issued an order
12. If a government agency is requesting the information for health oversight activities I may be required to provide them
13. If a patient or client files a lawsuit or professional complaint against me I may disclose relevant information regarding the patient in order to defend myself

14. If a patient files a worker's compensation claim, I must, upon appropriate request, provide records relating to treatment for which compensations is being sought

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your clinical record. It includes information about your reasons for seeking therapy, a description of the way 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 part of treatment records that I receive from other providers, reports of any professional consultation, your billing records, and any reports that have sent to anyone, including reports to insurance carriers. 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. You should be aware that pursuant to Texas law, Mental Health test date is not part of a patient record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. I am allowed to charge a copying fee as specified elsewhere in this agreement.

In addition, I also keep in some instances a set of Psychotherapy Notes; these Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of psychotherapy notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your clinical record. These psychotherapy notes are kept separate from your clinical record.

HIPAA provides you with several expanded rights with regard to your clinical record and disclosure of protected health information. These rights include requesting that I amend your record; requesting restriction on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent' having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this agreement, the attached notice form, and my privacy policies.

Custodian of Records

In order to provide continuity of care I authorize Life Balance Therapy to appoint an appropriate custodian of records in the event my provider is no longer with the facility.

PRIVACY NOTICE

I have read and understand the Privacy and Confidence Statement made available to me by Life Balance Therapy. I understand my rights as a client/ and or guardian and agree to any and all uses and disclosures of information under guidelines given to Life Balance Therapy, LLC by the Health Portability and Accountability Act (HIPAA)

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries. You may examine and/or receive a copy of your psychotherapy notes unless I determine that release would be harmful to your physical, mental or emotional health.

Cancellation Policy

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed **$50.00** for this appointment. The fee is charged for missed appointments, cancellation or rescheduled with less than a 24-hour notice. Payment for missed, same day cancellations or rescheduled appointments will need to be obtained before the next scheduled visit. If you do not return for services a bill will be mailed directly to clients who miss or cancel the appointment. Two missed appointments in a row without a 24-hour notice will constitute a discontinuance of therapy.

MEDICAL RECORDS

Please be advised that you will be responsible for a fee of $35.00 if you wish to obtain a copy of your mental health records or your child's mental health records. Payments must be made before we can release the records. Records requests are processed by your counselor and can take up to 14 business days to fulfill your request. Please be aware that medical insurance will **NOT** cover this fee.

An "Authorization for the Release of Information" form must be signed in order for our clinic to release mental health records to a parent/guardian, physician, school or any other entity. Please let our front office staff or your counselor know if you require this document. We will **NOT** release any information to a third party unless this form has been signed.

SHORT TERM DISABILTY/FMLA:

At the discretion of your clinician they may provide documentation for FMLA and Short-term disability requests. Our fee is $75.00 and includes a one-time completion of the forms, and may include writing a letter on your behalf. Please be advised our clinicians may require to meet with you for more than one session in order to obtain the appropriate information to complete your request to the best of their ability. The final determination of eligibility for FMLA and Short Term Disability is at the discretion of your insurance or employer.

OUTSTANDING BALANCE

Any balances remaining on the account after a claim has been filed to your insurance will be added to your patient account. If you do not return for services a bill will be mailed directly to you. Failure to pay any outstanding balance will result in your card on file being automatically charged the total balance on the account and/or balances being turned over to a third party for collections.

TELETHERAPY SERVICES

1. Teletherapy, by definition, is the delivery of therapeutic services by which the therapist and client are not within the same physical location. This includes, but is not limited to, Web Cam sessions, Telephone conversations, E-Mails, Text Messages, or any communication involving the Internet as a medium.

2. All teletherapy services are conducted within the state of Texas, and are governed by the laws of that state. Any teletherapy services conducted must be within the physical boundaries of said state. It is the responsibility of you, the client, to inform if this is not the case, in which teletherapy services cannot be offered.

3. As in face to face therapy, it is your right to discontinue therapy services at any time. It is within the rights of the therapist to discontinue therapy if therapist feels it is in the best interests of the client. If so, the therapist will provide three separate referrals by with to continue therapy with another licensed professional.

4. It is the responsibility of the client to provide their own equipment in order to conduct the teletherapy session. This includes a computer or tablet, a webcam or camera built into their device, and Internet access to conduct the session. It is the therapist's responsibility to provide similar equipment in their environment.

5. It is the responsibility of the client to make sure the environment chosen to conduct the teletherapy session is as private as possible. In this environment, it is the client's responsibility to keep distractions to a minimum. In addition, it is the responsibility of the client to protect confidential information within their own environment (prevent anyone from listening in to the session from someone else in the home). It is the therapist's responsibility to do the same in his environment.

6. Teletherapy sessions are conducted via AdvancedMD, a HIPAA-Compliant Videoconferencing solution. AdvancedMD provides encryption, and protects patient data via HIPAA, which is why it is chosen over Skype or other alternatives. Clients will be required to use this service to connect for teletherapy. Therapist will provide instructions on how to accomplish this. An email to access the electronic portal will be sent to you via email at the address provided on file, at the time the appointment is scheduled.

7. Teletherapy does not provide emergency services. If you are experiencing an emergency situation, call 911 or proceed to the nearest hospital emergency room for help, or contact your psychiatrist. If you are having suicidal thoughts, contact the National Suicide Prevention Lifeline at: 1-800-273-8255.

8. Clients have the right to request face to face counseling instead of teletherapy, as long as they can physically travel to the therapist's office, and agree to meet the schedule of the therapist. Client can discontinue teletherapy services at any time.

9. Clients have a right to access their medical information and copies of medical records in accordance with HIPAA privacy rules, and the rules of the therapist's licensing board.

I have read and understand the policies as written in this document titled "Clinical Informed Consent"

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Signature & Date