

ARMAND HOWARD MA, LPC
INDIVIDUAL, COUPLE, FAMILY & GROUP TALK THERAPY SERVICES

Professional Disclosure & Informed Consent

A tailored therapeutic process: Together we will create a safe way of discussing the intentions and concerns that you bring into talk therapy. We can aim toward your desired level of change and growth which, in large part, is based on your level of commitment to engage an inward search consistently both in and between sessions. This search can begin with identifying conscious thoughts and describing associated feelings, actions, moods, memories, urges, re-actions to stressful situations and dreams especially as they occur repeatedly or in cycles and patterns.

Moreover, the search is ultimately a discernment and talking in a therapeutic way toward decisions and actions that bear out a sense of authenticity and lead to greater satisfaction in the experience of life and in your relationships.

Therapeutic encounters are 50 minutes which means approximately 40-45 minutes are available to explore your concerns at whatever depth you choose. The starting and remaining 5-10 minutes is generally reserved for establishing safety and to discuss logistics. It's your choice as to whether to make your sessions lighthearted, so to speak, and/or deep. Either and both can be appropriate and while the therapist might press for one or the other, it is you, the client, who ultimately decides.

Remember, the additional service called the "virtual check in." These are a scheduled 20 minute conversation wherein the client leads a brief run-down of self-designated topics just to stay mindful of the actions taken that keep you healthy, well and/or flourishing. Topics range from the basic tenets of health and/or how you are processing current events and engaging insight learned throughout the therapeutic process.

For all services, however, managing the allotted time is a responsibility that both client and therapist share to maximize best outcomes of the process.

It is encouraged that between sessions you hand write, type, video/audio record descriptions of what you learn or want to learn along the way. This practice is known to facilitate greater self-awareness especially regarding dynamics that have otherwise been unconscious and possibly self-sabotaging.

Within sessions, all aspects of the process including techniques and experiments can be discussed for greater understanding and effectiveness. Your questions and feedback are a priority and are always welcome.

Effects of therapy: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing therapy. While benefits are expected from therapy, specific results cannot be guaranteed. Therapy is a personal exploration and may lead to major changes in your life. These changes may affect significant relationships, job/career, and understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of change cannot be predicted, but we will work together throughout the process to achieve the best possible results for you.

Client rights: Some clients need only a few counseling sessions to achieve their goals, others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time though it is asked that you participate in at least one termination session. You also have the right to refuse or discuss modification of any counseling techniques or suggestions.

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Services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time, for any reason you are dissatisfied with my services, please let me know and I will address your concerns. If I am not able to resolve those concerns, you may report your complaints to the Texas LPC Board at 1-800-942-5540.

Postponement, termination and referral: I reserve the right to postpone and/or terminate counseling of clients who come to their session under the influence of alcohol or drugs. I also reserve the right to discontinue or refer out any clients who do not comply with the medication recommendations of their psychiatrist or physician, those who consistently miss scheduled therapy sessions, or those whose clinical needs require a higher level of care.

Cancellation: If you are not able to make an appointment, please notify me at least 48 hours in advance. I reserve your scheduled appointment for you. Failure to cancel in advance, therefore, does not allow me to offer your time slot to other clients. As a result, you are responsible for a payment of \$50 for any and all missed sessions if adequate notice is not given.

Fees: Counseling services will be provided in return for an established fee. The fee is due by the end of each session. All reduced fees are provided incrementally and are subject to change. If you become involved in legal proceedings and require my participation (preparation and attendance), you will be expected to pay for professional time even if I am called to testify by other parties. The fee for participation in legal involvement is \$500 per hour.

Counseling relationship: During the time we work together, we will meet regularly for approximately 30 or 50 minute sessions. Although our sessions will include a friendly quality as well as appropriate therapeutic intimacy, ours is a professional relationship rather than a social one. I do not accept gifts or write references for clients. Also, should our paths cross in a public setting, I will not initiate conversation out of respect for your privacy and will only reciprocate briefly if you choose to engage first.

Records and confidentiality: All of our communication becomes part of the clinical record. Adult client records are disposed of seven years after the file is closed. Minor client records are disposed of seven years after the client's 18th birthday. Our communication is confidential with the following exceptions: **1) I determine that you are a danger to yourself or someone else; 2) you disclose abuse, neglect, or exploitation of a child, elderly, or disabled person; 3) you disclose sexual contact with another mental health professional; 4) I am ordered by a court to disclose information; 5) you direct me to release your records; 6) I am otherwise required by law to disclose information.**

In the case of couple or family sessions, I will keep confidential (within limits cited above) anything you disclose to me without your family members' knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge any "secret" to be detrimental to the therapeutic process.

Federal and state laws and regulations may also protect the confidentiality of your participation in counseling. The violation of federal requirements is a crime, and suspected violations may be reported. Federal regulations do not protect from disclosure of information related to a client's commission of a crime against Armand G. Howard, LPC, or reports under state law of suspected child abuse or neglect. (See 42 U.S.C. 290-3 for federal laws and 42 CFR Part 2 for federal regulations.) Federal regulations also do not protect from disclosure of information related to a client's threat of harm towards self or others.

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Please check one box according to your choice and write your initials next to each item after reading/understanding:

I choose to enter talk therapy with Armand Howard, to make the process a priority, to attend sessions consistently and punctually, and to engage an inward search toward deeper understanding of my concerns and intentions. I also choose:

A private fee of \$ _____ per 20 minute (check in sessions) and \$ _____ per 50 minute sessions.

Or

A pre-monthly auto-paid fee of \$ _____ which includes # _____ scheduled sessions of per month.

_____ These sessions can be rescheduled only if the schedule allows but cannot be refunded.

Any fee less than \$200 per session is a reduced fee and is subject to periodic assessment and adjustment. Adjustment is generally an increase but can be reduced briefly under extenuating circumstances as the continuity of the work is the priority.

Or

Behavioral health insurance benefits for 53 minute sessions based on diagnostic criteria.

_____ Services through insurance benefits are generally brief in duration as they are based on the measurement, reduction and/or resolution of diagnostic symptoms. Such services are also subject to your company's authorization and/or denial.

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- _____ Cancellation should be minimal, and the fee for missed sessions or cancellation w/in 48 hours is \$50.
 - _____ Requests for abrupt/frequent schedule changes and/or written letters are not included in the session fee.
 - _____ Sessions end on time (as safely possible) even when they start late, and time is co-managed by client & therapist.
 - _____ Severe symptoms, crises, and diagnostic conditions other than depression, anxiety, adjustment and/or grief are beyond the scope of this service and require referral to a higher level of care.
 - _____ Emotional discomfort is often part of the process, especially in the beginning.
 - _____ Home office check in process: park, text & stay, once you receive an all clear, walk over, ring and enter.
 - _____ Texting is for check in, scheduling, and other necessary communication but is to be generally minimal.
 - _____ Virtual encounters require both parties to be seated, alone in a safe quiet space.
 - _____ Public encounters may be initiated by client only and will be brief.
 - _____ Closure or transition is co-detected with as many sessions as needed but no less than one closure session (complimentary if need be).
 - _____ Medication noncompliance, intoxication, and consistent missing of sessions are all grounds for termination.
 - _____ The fee for participation in legal involvement is \$500 per hour regardless of outcome.
 - _____ I received a copy of the HIPPA privacy laws and informed consent for my review.

By my signature below, I am indicating that I have read and understand every section and every detail of this professional disclosure statement and contract, that any questions I have about this statement were answered to my satisfaction, and that I was furnished a copy of this statement. I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

Printed Name of Client

Date

Client Signature

Date

Therapist Signature

Date

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Name (print): _____ Cell phone: _____

May I leave voicemails? Y N (please circle one)

May I text you? Y N May we email you? Y N

Date of Birth: _____ Email: _____

Referral Source: _____ Your Occupation: _____

Emergency Contact Name & Phone: _____

Please list all individuals living with you (name, age, sex, type and state of relationship):

Other current significant individuals in your life (name, relationship type, age):

Marriage(s) or significant relationships of the past (name, relationship, date ranges):

Please provide details about your family of origin (names (living/deceased), ages, state of relationship):

How many hours of sleep do you average? _____ (circle the quality of your sleep below)

Excellent Fair In need of some help

How would you rate your knowledge of nutrition (the way food affects you physically & emotionally)?

Excellent Fair In need of some help

How would you rate your eating habits regarding nutritional value and consistency?

Excellent Fair In need of some help

Do you exercise? _____ If yes, what type & how often? _____

Circle your experience of daily stress? (mild) 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (severe).

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Do you drink alcohol? _____ If yes, how much & how often? _____

Do you use recreational drugs? _____ If yes, how much & how often? _____

Do you take prescription drugs? If yes, please list name, dosage & frequency.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Is there a family history of mental illness (including suicide attempt/completion) or substance abuse?

Y or N If yes, please describe: _____

Have you previously been diagnosed with a mental/behavioral health condition and/or engaged services including therapy, medication and/or hospitalizations? Y or N If yes, please describe:

Have you ever filed a complaint against a professional? Y or N If yes, please describe:

Have you ever participated in mental health coarse work or training of any type? Y or N

What is your highest level of formal education? _____

Please describe your current reasons for seeking talk therapy:

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Please describe how you would be different if our work in talk therapy were a success:

Do you claim any religion or spirituality? Y or N If yes, please describe:

Please describe any cultural influences that you feel I should know about you:

Please describe anything else you want me to know or think I should know about you?

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Notice of Privacy Practices

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact: Armand G. Howard, LPC, (214) 587-9030.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

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4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

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5. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

7. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

8. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

9. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI: You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Armand G. Howard, LPC, (214) 587-9030** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Armand G. Howard, LPC, (214) 587-9030**. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Armand G. Howard, LPC, (214) 587-9030** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Armand G. Howard, LPC, (214) 587-9030**. You must provide us with a reason that supports your request for

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amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Armand G. Howard, LPC, (214) 587-9030**. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Armand G. Howard, LPC, (214) 587-9030**.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Armand G. Howard, LPC, (214) 587-9030**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note:* we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Armand G. Howard, LPC, (214) 587-9030**.