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## INFORMED CONSENT

Welcome! I am committed to providing you with quality mental health care. This information packet is intended to acquaint you with what you can expect in therapy and to address some of the typical areas of concern, especially for the first-time client.

**Qualifications:** I attended Southern Methodist University where I majored in psychology and graduated with my Bachelor's degree in 2001. I then continued my education at the University of North Texas where I earned a Master's degree in counselor education. I am qualified to counsel according to the Texas Department of Health.

### SOME THINGS YOU SHOULD KNOW ABOUT COUNSELING

Before we start counseling together, there are some things that you should know about the counseling process and about my office. In legal terms, this is called "Informed Consent." This information will help you understand better what to expect from the counseling process and our work together.

### Your Privacy and Confidentiality

Of course, all of our work together – our conversations, your treatment record, and any information that you give me – is protected by something called legal *privilege*. That means that in most cases the law protects you from having information about you given to anyone without your knowledge and permission. My office respects your privacy, and I intend to honor your *privilege*. However, the law also makes some important exceptions to your privacy.

If I believe there is a risk you might harm yourself or someone else, I may be called upon to contact the authorities to give them the opportunity to protect you. If you are abusing children, an elderly person, or a disabled adult, I am required to notify the authorities, so they can protect others from harm. Also, if you become involved in any lawsuit in which your mental health is an issue – for example, a child custody dispute or a personal injury lawsuit in which you claim compensation for emotional pain and suffering – then the court or the lawyers may insist upon, and may obtain your information from me. That concern is especially important to understand if you are here for concerns regarding your marriage and later find yourself in divorce litigation. Similarly, you would lose the protection of your privilege if you sue me or if you file a complaint against me with a state licensing board.

The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or another third-party payer, my office must share certain information with them, including (but not necessarily limited to) your diagnosis and the times of your visits. If there is a managed care company involved, they may require me to provide additional information, such as your symptoms and your progress. You should also understand that insurance and managed care information is often stored in national computer databases. By your signature below, you authorize my office to provide information to your insurance and managed care companies to the extent necessary to enable them to pay for your services. If I find myself in a dispute with you over billing, my office reserves the right to employ a collection service and to provide them with any information necessary to clarify and to collect an outstanding balance.

Other charges may apply: If you, or someone else (for example, another counselor or your lawyer), needs a copy of your file or of other records that may be legally necessary, my office charges a reasonable fee for copying, plus postage. If I am required to provide a verbal report, for example by telephone to your physician, a ten-minute consultation will not be charged. If the consultation exceeds ten minutes, I charge $60 per hour; that fee is billed in fifteen-minute increments. If I must produce a written report, the same fee will be billed for the time spent reviewing your file and drafting and publishing the report.



Client Initials _____

**The Internet and Electronic Communication**

You may, at your discretion, use email or text message to communicate with me. If you choose to communicate via email or text, remember that these communications are not private. Email is, by its nature, subject to pass through a variety of email servers and thus subject to interception by unknown parties. Email communication with me should be limited to administrative and logistical matters; I will NOT use email or text to discuss important personal and counseling matters. If you wish to communicate via email and/or text, please provide your preferred email address and phone number:

*By my signature on this packet of information, I understand and I accept the limited privacy of email and text communications, and I authorize you to communicate with me at the following email address and phone number:*

_____

**Counseling Relationship**

While working together, you may share very personal details about your life, but our relationship is professional, not social. Please do not invite me to social gatherings, offer me gifts, ask me to write a reference for you, or ask me to relate to you in any way other than the professional context of our counseling sessions. Professional practice standards prohibit me from accepting requests to connect or be "Friends" on Internet sites such as Facebook, LinkedIn, Twitter, and other electronic and social media. You will be best served if our sessions concentrate exclusively on your concerns. Our in-person contact will be limited to counseling sessions you arrange with me. You may leave a voicemail for me at (972) 984-6392 and I will return your call as soon as possible. I am out of the office on various days and voicemails will be received and returned only during office hours. If you experience a mental health emergency, obtain crisis services by calling 911 and/or by going to a nearby hospital emergency room. You may also call the National Suicide Prevention Lifeline 24-hours a day at 1-800-273-8255.

By your signature below you authorize me to designate an appropriate professional to serve as custodian of your record and who will assume possession of, and responsibility for your treatment record in the event of my death or disability. In that event, notice and information will be posted, as necessary, on my web page (www.ozmercounseling.com) and shared on my telephone voicemail.

**Fees and Policies Regarding Litigation Services**

Ordinarily, I do not conduct evaluations in court- or litigation-related matters, nor do I customarily offer testimony in depositions or in court hearings. I believe that your interactions with me should remain private, and the success of your work depends, in some part, on protecting you and your information from disclosure. I will do all that I can to avoid offering information or testimony about you and your mental health in the context of litigation, although the courts or a lawyer may be able to require participation and disclosure. In the event I am required to respond to a litigation-related request there are some additional, specific considerations.

If I do become involved in litigation related to your treatment, you will be required to pay my litigation fees and for the cost of any appearance in court or for a deposition. By your signature below, you agree to the following and payment terms:

1. For any deposition or court appearance regarding your counseling, whether commanded by you and your lawyer, or by an adversarial lawyer or party, you agree to pay me $250 per hour from the time I leave my office until I return to my office.
2. You agree to pay at least two additional hours for me to review documents and to prepare for the court appearance.



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3. In addition to the contracted fees for your my time and appearance, if I believe it is necessary to retain an attorney to represent my interests, you agree, by your signature below, to reimburse me for attorney costs, up to a maximum of one thousand five hundred dollars ($1,500).

PRIVACY NOTICE

**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.**

In this Privacy Notice, "medical information" and "psychological information" mean the same as "health information." Health information includes any information that relates to:

1. your past, present, or future physical or mental health or condition;
2. providing health care to you; or
3. the past, present, or future payment for your health care.

Protecting Your Privacy

Licensed counselors must always manage psychological records with great concern for privacy and confidentiality. I am required by law to protect the privacy of your health information. This means that I will not use or disclose your health information without your authorization except in the ways I tell you in this notice.

If I wish to use or disclose your health information in ways other than those stated in this notice, I will ask you for your written authorization. If you give such an authorization, you may revoke it at any time, but I will not be liable for uses or disclosures made before you revoked your authorization.

Although the security of psychological records has continuously been addressed by Psychology Codes of Ethics as well as by State and Federal laws, the rules have been considerably strengthened by the provisions of the Health Insurance Portability and Accountability Act (HIPAA). The following information provides details about the provisions of HIPAA and your rights concerning privacy and your psychological records.

Who will observe these rules?

In my practice, the following individuals are required by HIPAA to comply with the privacy rules:

- Your treating therapist
- Any billing agency or collection agency that handles information about you (name and address, diagnostic codes, treatment codes, and consultation dates…but not actual clinical records)

**YOUR RIGHTS REGARDING PSYCHOLOGICAL INFORMATION ABOUT YOU:**

**The Right to Inspect and Obtain a Copy of Your Clinical Record**

Professional records constitute an important part of the therapy process and help with the continuity of care over time. The clinical record includes the date of your consultations, your reasons for seeking therapy, your diagnosis, therapeutic goals, treatment plan, progress, medical and social history, treatment history, functional status, any past records from other providers, and any reports to your insurance carrier; You have the right to inspect and receive a copy of your Clinical Record. Viewing your record is best done during a session, however, rather than on your own, in order to clarify any questions you might have at the time. I require that such a request must be submitted to me in writing, and I charge a nominal fee for accessing and photocopying a patient's record.

**The Right to Request a Correction or Add an Addendum to Your Clinical Record**

If you believe there is an inaccuracy in your clinical record, you may request a correction in writing. If the information is accurate, however, or it has been provided by a third party (e.g., previous therapist, primary care physician, etc.), it may remain unchanged, and the request denied. In this case, you will receive an explanation in writing, with a full



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description of the rationale. Additionally, you may request to place a copy of your written disagreement in your records. You also have the right to make an addition to your record, if you think that it is incomplete.

**The Right to an Accounting of Disclosures of Your Psychological Information to Third Parties**
You have the right to know if, when, and to whom your psychological information has been disclosed (exclusive of treatment, payment, and health care operations). However, you likely would already be aware of disclosures, as you would have signed consent forms allowing them (e.g., to other psychotherapists, primary care physicians, specialists, etc.). This accounting must extend back for a period of six years.

**The Right to Request Restrictions on How Your Information is Used**
You have the right to request restrictions on certain uses or disclosures of your psychological information, beyond what the law requires. These requests must be in writing, and most likely will be honored, although in some cases they may be denied. I do not use or release your protected health information for marketing purposes or any other purpose aside from treatment, payment, and other exceptions specified in this notice.

**The Right to Request Confidential Communications**
You have the right to request that I communicate with you about your treatment in a certain manner, or at a certain location. For example, you may prefer to be contacted at work, instead of home, or on a cellular telephone, to schedule or cancel an appointment. Or, you may wish to receive billing statements at a Post Office box, or at some other address. I prefer you submit such requests in writing, and be specific with respect to how/when/where to contact you.

**The Right to a Copy of This Notice Upon Request**
You have the right to request and obtain a copy of this Notice of Privacy Practices.

**The Right to Withdraw Permission to Disclose Health Information**
You have the right to withdraw permission you have given me to use or disclose health information that identifies you, unless I have already taken action based on your permission. In order to take effect, your request to withdraw permission must be submitted to me in writing.

**The Right to File a Complaint**
You have the right to file a complaint if you believe your privacy rights have been violated. Complaints must be filed in writing, and may be addressed directly to me or to the Secretary of the Department of Health and Human Services (address: Office for Civil Rights, 200 Independence Ave., S.W. Washington, DC 20201). If you have any questions or concerns about this notice or your health information privacy, please do not hesitate to address them during session or contact me by telephone (office: 972-984-6392).

**Right to be Notified in There is a Breach of Your Unsecured Protected Health Information (PHI)**
You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) our risk assessment fails to determine that there is a low probability that your PHI has been compromised.

**Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket**
You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.



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**HOW I MAY USE AND DISCLOSE YOUR PSYCHOLOGICAL INFORMATION:**

**For Treatment:**

I will access your record and use psychological information about you to assist in the continuity of your treatment and services. I will not share this information with other health care professionals, however, unless you specifically request it or agree to it, and sign a consent form to that effect.

**As Required by Law:**

It is possible (but unlikely) that the Department of Health and Human Services may review how my office complies with the regulations of HIPAA. In such a case, your personal health information could be revealed as a part of providing evidence of compliance. Additionally, I may be required by law to disclose health information about you in response to an order or subpoena issued by a regular or administrative court.

**Limits to Confidentiality:**

There are circumstances when I may break confidentiality, or I am required to break confidentiality and thus disclose your psychological information. This is accounted for under section 164.512 of the Privacy Rule and the state's confidentiality law. If I believe you are the victim of abuse or neglect, or perceive you to be a danger to yourself or others, I may disclose health information about you to the appropriate agency or individual (e.g., government agency, police, family members, relevant healthcare providers who may assist in taking protective action). Should such a circumstance arise, I will make every reasonable effort to discuss with you my ethical or legal obligations to disclose confidential information before doing so.

**Business Associates:**

My office may contract with a billing agency or attorneys to attend to business aspects on an as-needed basis. In this case, there will be a written contract in place with the agency requiring that it maintain the security of your information in compliance with the rules of HIPAA.

**Changes to this notice:**

Please note that this privacy notice may be revised from time to time. I will notify you of changes in the laws concerning your privacy and rights as I become aware of these changes. In the meanwhile, please do not hesitate to raise any questions or concerns you might have about your confidentiality.

_____ _____ _____

Client Printed Name Client Signature Date
Signed

_____ _____

Counselor Signature Date



Client Initials _____

**HIPAA NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ AND REVIEW IT CAREFULLY.

Effective August 1, 2010

**Use and disclosure of protected health information for the purposes of providing professional counseling services is sometimes required.** Providing treatment services, collecting payment, and conducting healthcare operations are necessary activities for quality care. State and federal laws allow me to use and disclose your health information for these purposes. Please read and initial each statement below:

_____**Treatment:** Use and disclose health information to:

- Provide, manage, or coordinate care to consultants, referral sources, or physicians
- Consult with other mental health professional(s) using client's first name only to ensure confidentiality and provide client with the best care possible
- As patient gives permission via "Informed Consent" form

_____**Healthcare Operations:** Use and disclose health information for:

- Review of treatment procedures
- Review of business activities
- Staff training and care within this practice
- Compliance and licensing activities

_____**Other Uses and Disclosures without Your Consent**

- Mandated reporting
- Emergencies
- Criminal damage
- As required by law

_____**Right to request where I contact you:**

| | | | | | |
|---|---|---|---|---|---|
| ▪ Home | yes | no | Email | yes | no |
| ▪ Work | yes | no | Street Address | yes | no |
| ▪ Cell | yes | no | Text message (cell) | yes | no |

- If none of the above, how may we contact you _____

_____*(Initial here)* **I have read and signed the professional disclosure statement. I agree to pay counseling fees at the time of service and understand the cancellation policy.**

By signing below, you attest that you have read and been made aware of your rights to confidentiality as a mental health consumer. Full HIPAA Compliance Rules and Regulations are posted in the counselor's office at all times and may be read by the consumer or copied for the consumer upon request.

_____ _____ _____

Client Printed Name Client Signature Date Signed

_____ _____

Counselor Signature Date



Client Initials _____