Paris Counseling Center, PA

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Phone 903.785.7410 Fax 903.785.7758
www.pariscounseling.com

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POLICIES & PROCEDURES AGREEMENT

Paris Counseling Center, PA exists to provide the residents of Northeast Texas and Southeast Oklahoma with quality counseling services that are Biblically centered. This mission is carried out by offering individual, marital and family counseling, and specialized groups.

THERAPIST TRAINING AND APPROACH TO COUNSELING:

Our therapists are Licensed Professional Counselors. Each therapist has obtained a minimum of a Master's degree, has completed an internship with supervision, has passed a board examination and receives continuing education in order to remain eligible for licensure.

Deborah Nations, LPC-S, is a Board-approved clinical supervisor for the Texas Licensing Board of Examiners. You may be offered the opportunity to receive counseling services, under clinical supervision, from a student intern or LPC-Intern who is completing requirements to receive his/her professional license. It is your option to accept these services.

Although no one can solve problems for you, it is hoped that through therapy you will be better able to understand your situation and feelings and move toward resolving your difficulties. Your therapist will use his/her knowledge of human development and behavior to make observations about your situation and suggestions for new ways to problem-solve. It is his/her responsibility to listen, understand and be helpful to the fullest extent of his/her professional ability. It is your responsibility to help your therapist understand your life situation, thoughts and feelings, and to have the courage to try new approaches in order for change to occur. It is important that you share with your therapist the goals you have for therapy and realize that entering therapy does not always guarantee anticipated outcomes.

On-going therapy is a negotiated process, and the need for follow-up appointments will be discussed with you at the close of each session. Whether or not you reschedule is always your choice. However, when therapy is completed or if you decide to discontinue therapy, a closure session with your therapist should be scheduled. When you schedule an appointment, your therapist is agreeing to set aside that time specifically for you. Successful therapy requires a commitment that is reflected in your willingness to utilize the time set aside for you.

Risks of Therapy: Therapy is the Greek word for change. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety or pain. The success of our work together depends on the effort put forth and the realization that you are responsible for life choices and changes that result from therapy.

Your signature & initials will be required on the last page as your consent to understanding the following sections of these Policies & Procedures. You will be given pages 1-4 for you to keep and refer to as needed.

SCHEDULING, ATTENDING AND CANCELLING APPOINTMENTS:

Appointments are made to set a specific time aside for you to meet with your therapist. Appointments are made by calling 903-785-7410 Monday through Thursday and speaking with the office manager. There is often a waiting list for prime-time appointments. Regular counseling sessions are 45-60 minutes in length. If you think your situation will require additional time, please request this when you schedule with the understanding that most insurance companies will only cover a single session in a day and an extended session may require additional payment on your part. Late arrivals should expect to forfeit the portion of the session missed. Please be respectful of the client scheduled after you and be mindful not to run over your allocated time. If you find it absolutely necessary to reschedule or change an appointment, **please call to cancel or reschedule at least 24 hours in advance**. Late cancellations will be charged $25.00 and no-shows will be charged $30.00 which must be paid in advance of your next session. If you are calling outside business hours, you may leave a voicemail 24 hours a day. Unless there are extenuating circumstances beyond your control, our policy is that following two unpaid no-shows or late cancellations, your case will be inactivated.

When making an appointment for a child, consent for counseling must be signed by the parent, or in the case of a divorce, by the managing conservator of the child, prior to the therapist's contact with the child. An initial appointment is scheduled with the parents (without the child) to obtain a history regarding the child's problem. **Please be prepared to provide a copy of the court order naming the managing conservator of the child.** It is our policy that both parents may be involved in a child's therapy.

Emergency situations may necessitate immediate attention. After hours, your therapist can be reached by calling the office at 903-785-7410 and following the instructions to leave a message on his/her voice mail and he/she will be alerted. If your situation escalates or becomes unmanageable prior to reaching your therapist, **please** contact your psychiatrist or physician or go to the nearest emergency room. You may also call 911. **Emergencies are urgent issues requiring immediate action.** Please do not use this procedure to schedule an appointment. Appointments may be scheduled by calling the office at 903-785-7410 during office hours or you may leave a message on our voicemail and your call will be returned the next business day.

TELEPHONE CALLS:

Please call 903-785-7410 to schedule, confirm or cancel appointments, provide personal or insurance information. You may leave a message on the voice mail during lunch hours or after regular business hours. Do not leave a message on your therapist's voice mail regarding scheduling or insurance information. You may occasionally need to speak with your therapist between appointments. Please leave the message with the office manager. You must understand that your therapist generally has clients scheduled in succession throughout the day and phone calls may not be returned until several hours later. Please give numbers where you may be reached currently and later. You will need to leave a message briefly stating what you need to discuss with the therapist so that it may be determined if the office personnel can handle your request and so that the therapist may appropriately prioritize your call. Should these types of calls become frequent or extended in length, please be aware that you may be subject to a phone consultation charge of $30.00 per 15-minute unit. These charges will be expected to be paid before the next appointment and are not covered by insurance plans. If you require consultation with your therapist that extends beyond a brief conversation, you will need to make an appointment for a face-to-face session. The same policy may apply to phone calls which are necessitated between your therapist and other professionals in your behalf, such as physicians, attorneys, other service providers, etc.

EMAIL and TEXTING:

Federal and Texas Law, as well as our Professional Code of Ethics, require that your Protected Health Information be kept private and secure. Email and texting cannot be guaranteed to be secure, or error-free, as transmitted information can be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. Therefore your use of these methods of communication indicates your acceptance of this risk. Our practice management system allows for secure encrypted email between an established client and the therapist if transmitted through the system. Instructions for setting up email are available from the office manager.

EXPECTATIONS FOR PAYMENT OF SERVICES:

Paris Counseling Center, PA will look to you for full payment of your account at the time of your appointment. Gifts, bartering and trading services are not appropriate. Your insurance company or other applicable program may cover benefits for the treatment of mental health issues. We are willing to bill your primary and secondary insurance companies for the portion of the fee they are responsible to pay for therapy, PROVIDED we have a contract with that payor and PROVIDED the services are preauthorized. If you have a third insurance, we will provide you with the necessary information for you to file the claim. **You are responsible at the time of each session for any co-payment or co-insurance amounts or deductibles due**. Our office will attempt to preauthorize services for you; however, **IT IS YOUR RESPONSIBILITY** to ensure that the requirements of your particular insurance company for preauthorization of services are met. Please be prepared to submit a copy of your insurance card at each appointment. Medicaid cards should be submitted each month.

Your signature on this form denotes your understanding and agreement that if your plan fails to pay for any reason, including bankruptcy of the company, YOU ARE RESPONSIBLE FOR ANY UNPAID BALANCES and, upon notification, will promptly pay what is due.

In the event that your therapist is not a participating provider for your particular insurance company, he/she will accept you as a private pay client with full payment due at time of appointment. We will provide you with the appropriate information necessary for you to submit an out-of-network claim to your insurance company in order that you may be reimbursed directly. Insurance companies normally pay for a 45-60 minute individual therapy session for the covered patient. **INSURANCE COMPANIES NORMALLY DO NOT PAY FOR ADDITIONAL TIME SPENT IN SESSION, TELEPHONE EMERGENCIES, COURT TESTIMONY, MARRIAGE AND FAMILY THERAPY, OR NO-SHOW/LATE CANCELLATION FEES**. Insurance companies require your therapist to provide a diagnosis and information about your therapy in order to determine your eligibility for benefits and to receive reimbursement. In addition, it may be necessary to coordinate services with your primary care physician.

The fee for the initial assessment and development of a treatment plan to reach your goals is $150.00 per hour. Individual counseling fees for therapists are $110.00 per 45-minute session and $125.00 per 60-minute session. Sessions that exceed the scheduled time will be billed at the pro-rated amount and are <u>your</u> responsibility. Fees for marriage therapy, family therapy and telephone emergencies are $125.00 per 45 minutes. Initial assessments are very important to gather essential information, to clarify and set goals for your therapy, and to enhance the overall successful outcome of the therapy process.

COURT TESTIMONY:

Should your therapist be subpoenaed to provide court testimony regarding your therapy, fees are $200.00 per hour. This fee will apply for consultation with clients or attorneys in-person or by telephone, reproducing records, written reports, preparation to testify, travel time, time waiting to testify, and for actual time testifying before the court. Mileage and other expenses will also be billed.

A payment deposit of $500.00 - $2,500.00 is required by the time that your therapist is notified that his/her court testimony services will be needed. Your therapist may choose to be "on-call" to appear in court, or may choose to have you or your attorney reserve the predicted time they will be needed in court in order that other clients may be protected from losing their appointment time if the therapist is called to court. Any time reserved will be billed and the amount will not be refundable in case of cancellation or postponement of court proceedings without at least 72 hours notice. Any expenses for an out-of-town court appearance (mileage, airline tickets, hotel, etc.) will need to be paid in advance.

CONFIDENTIALITY:

Discussions between your therapist and you are **private**. It is the therapist's goal to protect the confidentiality of your Private Health Information (PHI). In almost all cases, it is the therapist's intent to use your PHI or share with other professionals only for the purposes of providing treatment to you, arranging for payment of services

or for business functions called health care operations. In addition, you may at times give your therapist and Paris Counseling Center, PA written authorization to disclose your PHI to another person for the purposes you designate. While we make every effort to provide confidentiality, we cannot assure the confidentiality of family members or other individuals you may include in your therapeutic process. We also cannot insure the confidentiality of your information once it is released to others.

Living in a small community, there may be occasions when you see your therapist outside this office. In an effort to protect your privacy, your therapist will not initiate conversation or discuss clinical issues with you in social situations. Your relationship with the therapist is professional and therapeutic. Personal and/or business relationships can deter the effectiveness of therapy and should be avoided.

The following are legal exceptions to your right to confidentiality. Your therapist would inform you any time he/she would put these exceptions into effect.

1. If there is good reason to believe that you will harm another person, your therapist must attempt to inform that person and warn them of possible danger. Your therapist may also contact law enforcement officials and ask them to protect the intended victim.
2. If child/adult/disabled abuse or neglect is reported, your therapist must inform Child Protective Services or Adult Protective Services.
3. Testimony and disclosure of your record may occur if subpoenaed by the courts.
4. Your therapist and Paris Counseling Center, PA may use or disclose your PHI to defend a complaint to the licensing board or in a negligence suit brought against them by you.
5. In the event that your therapist reasonably believes that you are a danger, physically or emotionally, to yourself, you give consent for him/her to contact medical and law enforcement personnel and to notify the person(s) you designate.

Therapist's/Client's Incapacity or Death: In the event that your therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of your files and records. By signing this form, you give your consent to allow another licensed mental health professional selected by your therapist and/or Paris Counseling Center, PA to take possession of your records and provide you with copies upon request, or to deliver them to a therapist of your choice.

Confidentiality also extends beyond your death. You may designate to whom you would like your records released in the event of your death.

PRIVACY PRACTICES: The Privacy Practices of Paris Counseling Center, PA are discussed in further detail in the Notice of Privacy Practices brochure. This notice describes how medical information about you may be used and disclosed. Please review it carefully. Your signature on this Policies and Procedures Consent denotes that you have received a copy of the Notice of Privacy Practices (NPP) and understand that we operate under these practices as mandated by law. (If you have any questions regarding confidentiality or the Privacy Practices of Paris Counseling Center, PA, you should bring them to the attention of your therapist or the Designated Privacy Officer noted on the NPP.) Your signature also denotes your consent for your therapist and Paris Counseling Center, PA to use and disclose your PHI as outlined above and as clarified in the attached NPP. You are also releasing and holding harmless Paris Counseling Center, PA, its therapists and its employees from any departure from your right of confidentiality that may result.

CONSENT TO POLICIES AND PROCEDURES

Please put your initials in the blanks on this page to indicate that you have read and understood each section of the Policies and Procedures Agreement. Each blank should be completed. <u>Return this page to Paris Counseling Center and retain pages 1-4 for your records.</u>

_____ *initial here*

I have read and understand the section on **Scheduling, Attending and Cancelling Appointments**. I understand that I must give 24 hours notice to cancel an appointment or a $25.00 fee for late cancellation or $30.00 fee for no-show of appointment will be charged.

_____ *initial here*

I have read and understand the section on **Telephone Calls.** I understand a charge may apply for frequent or extended telephone consultations with my therapist.

_____ *initial here*

I have read and understand the section on **Email and Texting**. I acknowledge that my health information cannot be guaranteed to be secure and kept private through email and texting, and that my use of these methods of communication indicates my acceptance of this risk. I understand that I can set up secure encrypted email through the practice management system.

_____ *initial here*

I have read and understand the section on **Expectations for Payment of Service**. I understand that payment in full, or if covered by insurance, co-pays / co-insurance amounts or deductible amounts are **<u>due at the time of my appointment</u>**. I understand that if my insurance plan fails to pay for <u>any</u> reason, I am responsible for full payment of the session(s) immediately upon being notified.

_____ *initial here*

I have read and understand the section on **Court Testimony.**. I understand that if I request my therapist to provide court testimony regarding my counseling, **I must pay a deposit of $500.00 - $2,500.00** toward expenses. This is payable at the time I notify the therapist that testimony may be needed. I understand that the court testimony rate is $200.00 per hour and that charges will apply for consultation with clients or attorneys in-person or by telephone, reproducing records, written reports, preparation to testify, travel time, time waiting to testify, and for actual time testifying before the court, plus mileage and expenses. Any time reserved on the therapist's schedule for court will be billed and in the event of cancellation or postponement is non-refundable without 72 hours notice. The balance of any deposit not billed will be refunded. I understand my signature denotes my agreement to pay the required deposit and other court-related charges.

Please complete the back of this page.

_____
initial here

I have read and understand the section on **Confidentiality**. I understand that there are some limits on confidentiality. If at any point my therapist reasonably believes that I am a physical or emotional danger to myself or others, I give him/her consent to contact the following person(s):

NAME ADDRESS PHONE RELATIONSHIP

_____

_____

In the event of my death, I give my therapist consent to release my records to the following:

NAME ADDRESS PHONE RELATIONSHIP

_____

In the event of my therapist's incapacity of death, I give consent to Paris Counseling Center, PA to release my records to a therapist of my choice or to another licensed mental health counselor chosen by my therapist and/or Paris Counseling Center, PA.

_____
initial here

I have read and understand the section on **Privacy Practices**. I acknowledge that I have received a copy of the Notice of Privacy Practices. I give consent to my therapist and Paris Counseling Center, PA to use and disclose my Private Health Information as outlined and as clarified in the Notice of Privacy Practices. I also release and hold harmless my therapist and Paris Counseling Center, PA from any departure from my right of confidentiality that may result.

_____
initial here

I hereby grant **informed consent to treatment**. I voluntarily agree to receive mental health services for myself and family members noted below and authorize Paris Counseling Center, PA and its therapists to provide such mental health services considered necessary and advisable to myself and other listed below:

_____

I understand and agree that I will participate in the planning of my therapy and that I may stop such therapy, I receive through my therapist & Paris Counseling Center, PA, at any time.
I agree to discuss with my therapist any questions or concerns I have about my therapy and to schedule a closure session when therapy ends. Should a dispute arise between me and my therapist and/or Paris Counseling Center, PA, I agree to good faith mediation to find a resolution.
I consent for my therapist and personnel of Paris Counseling Center, PA to communicate with me by mail and phone at the following location, and agree that I will IMMEDIATELY advise the office in the event of any change:

ADDRESS PHONE

_____

By my signature below, I confirm my understanding of and my consent to the stipulations set forth in this Policies and Procedures Agreement.

_____

Client (or parent/guardian if client is a minor) Date

_____

Client's Address Client's Social Security Number

as witnessed by:_____

for Paris Counseling Center, PA Date