**COUNSELOR‑CLIENT SERVICES AGREEMENT**

**Whitney Humphrey, PhD, Licensed Marriage and Family Therapist and Board Approved Supervisor**

Welcome to my practice. This Agreement contains important information about my professional services and office policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new client rights 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 Agreement, 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 very important that you read them carefully before our next 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, 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.

**THE PROCESS OF COUNSELING:** Counseling is not easily described in general statements. It varies depending on the personalities of the client and counselor, the particular problems being addressed and the approaches used. Participation in counseling, moreover, can result in a number of benefits to you, including insight, improvement of interpersonal relationships, reduction in feelings of distress and resolution of specific problems. Working toward these benefits, however, requires effort on your part both during and between sessions. Counseling is a collaborative process that necessitates your active involvement, honesty, and openness in order to progress toward your goals. Given the work required for personal growth and change to occur, counseling can also involve risks. Since counseling often involves discussing difficult aspects of your life, you may experience uncomfortable feelings or strong reactions. Making changes in your life can sometimes be disruptive to your current relationships as well as challenge long held assumptions or behaviors. There can be no guarantees in counseling, due to the overall complexity of this process and the multiple variables brought into it by each individual client.

Counseling begins with an evaluative process that typically lasting three or four sessions though the length may vary depending upon your situation. During these initial sessions a working understanding of the problem(s), therapeutic objectives, treatment plans and possible outcomes will be discussed. Therapy can involve a substantial investment of time, energy and financial resources; you should be very selective when choosing a counselor. A decision to pursue counseling, moreover, should be mutually explored. You are encouraged to ask any unanswered questions and discuss any concerns you may have regarding the counseling process itself, my qualifications and your comfort level in working with me as you decide whether to pursue counseling. I also will feel free to explore any questions that, I may have regarding establishing a therapeutic relationship with you as part of my assessing whether I can be of assistance. If it is determined that your needs will be better served by someone else, I will assist you with a referral.

The duration of counseling differs for each individual. Factors such as goals, motivation, life circumstances, and duration/extent of the issue(s) determine whether treatment requires weeks, months, or years. We will periodically discuss your progress. You will be encouraged to express your thoughts and feelings regarding your counseling and our therapeutic relationship. It is important that any concerns either of us might have about the appropriateness or effectiveness of treatment be addressed. When it is indicated, I will recommend adjunctive counseling (e.g. group counseling), medical evaluation, psychological testing, or referral to another counselor or treatment modality.

Counseling is a voluntary process; while you have the right to discontinue at any time, collaboratively exploring and discussing termination is an important part of the counseling process. It is important for you to initiate a discussion about termination if you are considering it.

**APPOINTMENT SCHEDULING:** I will usually schedule one session per week; a regularly scheduled appointment will be worked out as one becomes available. Your collaboration regarding the punctuality of starting and ending sessions at the appointed times will be appreciated. Sessions may, by previous arrangement, vary in length or frequency. Adjunctive therapies, such as weekly group counseling, may be recommended and scheduled as appropriate.

**CANCELLATIONS:** A minimum of 24 hours (i.e. one full business day) notice is required for cancellation of an appointment. For example, a 9:00 a.m. Monday appointment would need to be cancelled by 9:00 a.m. of the preceding Friday. The full fee will be charged for missed appointments without such notification. Exceptions will be discussed as appropriate.

**FEES:** My basic fee is $150 per 45-50 minute and $225 per 75-80 minute individual, couples, or family counseling session. You will be informed in advance of any fee increase. You may anticipate periodic review (typically annually) of my fees. If you become involved in legal proceedings that require my participation (including preparation and attendance), I charge $200 per hour because of the complexity of such involvement. My fee for written documentation is the same as your session fee (maybe adjusted depending on the involvedness).

**PAYMENT FOR SERVICE:** You are expected to pay for services at the time they are provided. Payment may be made by check, cash or through paypal. You are responsible for payment of all fees. You will be responsible for returned check fees charged by banks. Professional collection may be utilized if accounts become 90 days past due; such action would involve disclosure of your name, nature of service provided and amount due.

It is important that you determine the resources (insurance and/or out of pocket) available to you so that you can make a realistic assessment regarding your ability to pursue the recommended course of counseling. Should it be unrealistic for you to complete the recommended treatment, I will be happy to assist you in identifying other therapeutic options such as counselors who use a sliding scale, clinics or selection of a counselor from your provider list.

**TELEPHONE AND AFTER‑HOURS PROCEDURES:**  I am typically not immediately available by phone. My telephone is answered by voice mail. I make an effort to return your call on the same business day. Calls received after business hours, weekends, or holidays will be responded to upon my return to the office. Telephone calls typically are limited to scheduling arrangements. Telephone counseling sessions may be considered and scheduled under certain circumstances. When I will be unavailable for an extended time (such as vacation), I will provide you with the name of a colleague to contact, if necessary, and/or leave that information on my voice mail. If you need immediate emergency assistance, contact your family physician, the nearest emergency room, or one of the services listed below:

24‑hour Help Line 472-4357

Shoal Creek Psychiatric Hospital 452-0361

Brackenridge Hospital Emergency 324-7010

Safe Place 277-SAFE

General Emergency Number 911

**INCLEMENT WEATHER:** In the event of inclement weather, please call my telephone number to hear instructions. If area schools are closed and there is a travel advisory, my office will be closed. If the situation is unclear, take care to ensure your safety. Please call to advise regarding cancellation and to request for rescheduling of your missed appointment.

**INDEPENDENT PRACTICE:** I am an independent practitioner and have no professional affiliation with any of the other counselors who practice in this office building.

**ETHICAL AND PROFESSIONAL STANDARDS:** As a Licensed Marriage and Family Therapist, I abide by the ethics and standards of my profession. I will be pleased to discuss any questions you may have regarding these guidelines; I will initiate such discussions as needed. My policy regarding issues such as requests for bartering or receiving a gift is to make that decision in collaboration with a client. The firm underlying principle in decision making is focus on what is in the best interest of the client and his or her therapeutic progress. Any questions regarding these complex issues should be initiated prior to any decision.

**RECORDS:** You should be aware that, pursuant to HIPAA, I keep protected health information about you. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. 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, psychological test data are not part of a patient's record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If I choose to review your records, therefore, I recommend that you 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 (and for certain other expenses). The exceptions to this policy are contained in the attached Notice. If I refuse your request for access to your Clinical Record, you have a right of review, which I will discuss with you upon your request.

In addition, I may keep a set of Counseling 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 Counseling Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They may also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Counseling Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Counseling Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Counseling Notes unless I determine that release would be harmful to your physical, mental or emotional health.

**CLIENT RIGHTS:** HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions 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 and the Notice .

**CONFIDENTIALITY:** The law protects the privacy of communications between a client and a clinician. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

* I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will use my discretion to determine whether it would be beneficial to discuss these consultations with you.
* Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
* I have a professional will which includes a list of my clients which can be accessed by a pre-determined responsible counselor in the case of my death or serious disability so that your needs at that time could be addressed.
* If a client seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. Texas law provides that a professional may disclose confidential information only to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the client to himself/herself or others, or there is a probability of immediate mental or emotional injury to the client.

There are some situations where I am permitted or required to disclose information without either

Regarding minors, it is my policy that parents respect the privacy of your counseling. The law may provide your parents or legal guardians the right to review your treatment records if you are under eighteen years of age. I will ask your permission to discuss your counseling with them in response to their questions and/or as you or I feel would be helpful. When doing so, I will endeavor to offer only general information about your counseling, unless we have agreed otherwise. Exceptions to this include imminent threat of harm to oneself or others, and child abuse or neglect; these situations are discussed in the Notice.

Your consent or Authorization:

• If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist‑patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in, or contemplating, litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

• If you tell me of a sexual involvement with a mental health professional who was involved with your care, I am required to report this to the appropriate State Board.

• If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

• If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

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

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

• If I have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that I make a report to the appropriate governmental agency, usually the Department of Protective and Regulatory Services. Once such report is filed, I may be required to provide additional information.

• If I determine that there is a probability that the client will inflict imminent physical injury on another, or that the patient will inflict imminent physical, mental or emotional harm upon him/herself, or others, I may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the client.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

Issues related to the complexity of confidentiality and management of neutrality in couples and family counseling will be discussed as needed. When a couple or a family is the client rather than an individual, it will be necessary to establish clarity about sharing information. If a change of format involving who is the client becomes necessary or useful, there will be discussion and disclosure of issues related to such a change.

Members of counseling groups are required to maintain confidentiality regarding the identity of group members and personal information disclosed during group sessions.

While this written summary of confidentiality and exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex; in situations where specific advice is needed, formal legal advice may be required.

**Name**: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_