Perceptions
Counseling Solutions, LLC

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient 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. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the clinician and client, and the particular problems the client is experiencing. There are many different methods I may use to deal with the problems that we hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and in the time between sessions. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience. Our first session or two will involve an evaluation of your needs. By the end of this time, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I'm the best person to help you create the life you want. If we decide to continue, I will usually schedule one 50-minute session per week, although duration and frequency can vary.

INSURANCE REIMBURSEMENT / PAYMENT OF FEES

You will be expected to pay for each session at the time it is held, prior to the beginning of the session. Payment schedules for other professional services will be agreed upon when they are requested.

If you have insurance, please understand that this is an agreement between you and your insurance company. If your insurance requires an authorization for your visits, please make sure that you obtain this authorization before your first appointment. If your insurance company denies your visits for any reason, you will be responsible for the full fee of each of these visits. Please be aware that insurance benefits quoted by your insurance company are not a guarantee of payment and that you are ultimately responsible to know the benefits of your policy. If you insurance company requires a deductible, Perceptions Counseling Solutions, LLC will accept a payment of $85 for the first session and $65 for future sessions, until the deductible has been met. We would also ask you to please be aware of the status of your deductible.

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (by Friday at 5pm for Monday appointments), or unless we both agree that you were unable to come due to a medical emergency. I will do everything possible to find another time to reschedule the appointment that week, but a late cancellation will still mean you are responsible for the fee for that missed session.
_____ (initials)

CONTACTING ME

Due to my work schedule, I am often not immediately available by phone. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day. Otherwise, you can expect a return call on the next business day, at the latest. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room, or call 281-CARE.

RELEASE OF INFORMATION

I understand that in the course of my treatment, it may be necessary for Perceptions Counseling Solutions, LLC to share my mental health information with other specialists, physicians, and/or health care agencies. Mental health information may also be shared with my insurance carrier in order for Perceptions Counseling Solutions to receive payment for services covered under my insurance plan. I assign to Perceptions Counseling Solutions all insurance benefits applicable and authorize my insurer or third-party payment program to render payment of such amounts directly to Perceptions Counseling Solutions. I understand that the therapists within Perceptions Counseling Solutions may consult with other therapists in order to enhance my treatment.

NOTICE OF PRIVACY PRACTICES

Perceptions Counseling Solutions, LLC is committed to the protection of your mental health information as required by federal and state law. Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

- **Duty to Warn and Protect**
  When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

- **Minors/Guardianship**
  Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

- **Abuse of Children and Vulnerable Adults**
  If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

- **Prenatal Exposure to Controlled Substances**
  Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

- **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.

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of PHI. 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 PHI that you have neither consented to nor authorized; determining the location to which PHI 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.

I am happy to discuss any of these rights with you. Your signature below indicates that you have read this agreement and agree to its terms.

I certify that I have read and fully understand the Consent for Treatment and Payment form, and agree to the Notice of Privacy Practices and the Policies & Fee Schedule.

Signature_____ Date _____

Perceptions
Counseling Solutions, LLC

Client Registration

Client Information

Name _____

Address _____

City_____ State_____Zip _____

Phone_____Work/Mobile Phone _____

Date of Birth_____Social Security Number _____Marital Status_____

Patient's relationship to insured ☐Self ☐Spouse ☐Child ☐Other: _____

If other than self, please complete:

Insurers Name _____

Address _____

City_____State_____Zip _____

Phone_____Work/Mobile Phone _____

Date of Birth_____Social Security Number _____

Employer _____

Insurance Plan _____
Address _____
City_____State_____Zip _____

Policy Number_____Group Number _____

Emergency Contact Information

Name_____Relationship _____

Phone_____Work/Mobile Phone _____