Counseling Connections for Change, Inc.

Mental Health Matters!

Client's Printed Name: _____ Client's Date of Birth: _____

Current Home Address: _____

Street (apt. #) City/State Zip Code

PROFESSIONAL SERVICES AGREEMENT

Counseling Connections for Change, Inc. is a nonprofit, 501 (c)(3) agency dedicated to providing excellent care for you and your family, and we appreciate your confidence in choosing us to help you with your mental health needs. This document serves as a contractual agreement between our agency and you, as well as provides information about our standard business practices. If you have any questions or concerns, we welcome your feedback, and encourage you to discuss your needs with your assigned provider (clinical staff and/or education facilitator).

You may revoke this agreement in writing at any time. That revocation will be binding unless clinical or support staff have taken action in reliance on it; if there are obligations imposed on our office by your health insurer in order to process or substantiate claims made under your policy; if there are any pending legal cases in relation to the document contents; or if you have not satisfied any financial obligations you have incurred.

_____ Appointments***:*** Scheduled therapy times are reserved for you with your therapist, and typically last 45 minutes. There may be extended sessions. If you are unable to keep an appointment, a 48-hour notice is required to avoid a $35 late cancellation fee. **Two consecutive unmet appointments, where a 48-hour notification was not provided, will result in the removal of all future appointments from the schedule.** Prior to rescheduling, all late fees will need to be paid.

_____ ***Risks and benefits of therapy:*** The therapy experience can vary depending on the personalities of the therapist and patient, and the particular problems you are experiencing. Various intervention strategies may be used to help accomplish the goals you set, but unlike a medical doctor's intervention, psychotherapy requires more frequent attendance as well as active participation in order to achieve intended outcomes. For the best results, you will need to work on things that are discussed both during sessions and at home. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. 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. Response to therapy is different for each client.

_____ ***Title, training, and expertise of my provider:*** For all therapy services, all providers are duly licensed to assess and treat mental health needs in the State of Texas with the exception of student internship placements as defined below. All licensed interns to include LPC-I, LMSW and LMFT-A are under supervision and meet weekly with their supervisor to receive clinical guidance and support and obtain full licensure. For prevention and skill-building education services, all providers are properly trained in the course for which they are responsible for facilitating. A biography of your therapist is available, and you have the right to inquire fully about his/her background, credentials, education, and professional experience.

_____ ***Student internship placements:*** Among the services provided at Counseling Connections for Change, Inc., we support the educational advancement of undergraduate and graduate students through partnerships with local universities. Student interns have completed the necessary college level coursework and are supervised by the Clinical Intern Manager, who meets weekly with the student to insure best-standard practices are employed. Student interns benefit in being able to observe therapy sessions.

I give permission for my counselor to have a student intern participate in my treatment.____

If you are unwilling to have a student intern participate in your treatment, please indicate here.____

____ ***Video recording of Counseling Session:*** At times, students will request their sessions be video or audio recorded for supervision purposes only. The audio or video will be used only for the purposes of professional training, consultation and/or improving skills in supervision. Recordings are erased after the supervision takes place.
I give permission for my counselor to audio or video record all or part of our counseling sessions.____

If you are unwilling to have a student intern video or audio record portions of your sessions, please indicate here._____

_____ ***Type, length and alternative approaches to intervention:*** Therapy services typically last between 8-10 sessions once the assessment is complete and treatment goals are established. Types of therapy interventions are dependent on your unique needs, and should be thoroughly explored between you and your provider. At times your provider may recommend additional assessments to gain a clearer understanding of your needs, or you may be encouraged to attend one of the many prevention and skill-building education courses to expedite your therapy experience. If at any time you have questions about your treatment plan or the clinical procedures, it is your responsibility to communicate those concerns with your provider. At all times, you are welcome to contact the Clinical Manager for our agency. If it is determined that your needs would be better met elsewhere, your provider will assist you in this transition if you so choose.

_____ ***Professional consultation:*** Professional consultation is a healthy part of maintaining best practice standards, and your therapist will routinely participate in ethical, clinical, and legal consultation with other professionals. During these consultations, none of your personally identifiable information will be disclosed without your expressed written consent.

_____ ***Contacting your provider:*** Successful goal achievement depends on open communication, which can typically be conducted during the course of your scheduled appointment; however, should there be an emergency, you are responsible for seeking the appropriate level of care, which may include calling 911 or going to your nearest emergency room. Counseling Connections for Change, Inc. is not equipped for crisis response, and cannot respond after normal business hours. A 24-hour voicemail service is provided for your convenience, so if you need to speak to your provider outside of the scheduled appointment, please leave a detailed message, and every effort will be made to return that call within the week with the exception of weekends, holidays, and agency closures. Standard hourly rates will be billed for any phone consultations or therapy services exceeding 15 minutes, and insurance companies will not reimburse for this expense.

_____ Filing ***a grievance:*** If you have concerns about your service experience, you are encouraged to discuss these issues with your provider first, but always have a right to consult the Clinical Manager and/or the Chief Executive Officer for Counseling Connections for Change, Inc. For further action, please refer to our posted licensing contacts in the lobby.

_____ ***Confidentiality:*** Your privacy is important to us and is protected through our business practices and the law. In most situations, your written consent is required for any release of information; however, there are some instances where your privacy is limited and confidentiality cannot be guaranteed.

- COUPLES OR MARITAL COUNSELING: If you are seeking couple's counseling, it is imperative that you understand that open communication between all participants and the provider is necessary for successful goal achievement; both participants will have equal rights to the clinical records and neither participant will have confidentiality rights within the therapy process. Please list both participants' names here: _____
- FAMILY COUNSELING: If family counseling is the recommended course of treatment, you agree that privacy is limited and open communication within the family system while in therapy is necessary. However, different roles of authority and responsibility i.e., parent-child, may require separated sessions to maintain best-practice standards. Through the assessment process, your therapist may recommend individualized treatment outside of the family therapy setting. In these instances, the therapist will make an appropriate referral to meet the overall needs of the

family. Please list all family members and ages who will be participating in the treatment process. _____

- GROUP COUNSELING: A variety of group counseling services are available to our clients, and can provide a rich environment for processing some of life's most challenging experiences. If you have chosen to participate in group counseling, you are encouraged to openly share for the maximum benefit. To preserve your privacy and the integrity of the group, we ask that all members refrain from using last names or any non-relevant identifying information. Insurance is not filed for any group therapy services. Please list the name of the group you will join: _____

- PREVENTATIVE/SKILL-BUILDING EDUCATION PROGRAMS: Prevention and education programs are critical components to the overall success of a counseling experience, which is why our agency has invested in the promotion of programs designed to strengthen mental health, improve relationships, and prevent tragedies. While relevant to your experience, these classes are not considered therapy services, and cannot be billed to your insurance company. Please list the name of the class you plan to attend: _____

- ONLINE THERAPY SERVICES: Under certain circumstances, online therapy services may be available for you or your family members, and every effort will be made by Counseling Connections for Change, Inc. to secure privacy of the session. It is your responsibility to insure your end of the line is secure and free from any distractions. Online therapy services are billed at the standard hourly rates of traditional therapy, and insurance cannot be billed.

- FACILITY USAGE: Since moving to our location at 2549 Roy Road, we have been blessed with opportunities to hold some sessions outdoors, which can be beneficial to your overall mental health experience, and may ultimately contribute to achieving your desired goals. If you and your therapist determine this is in your best interest, you may choose to take the session outdoors. While your provider will use discretion during each outdoor session, understand that complete confidentiality will be limited due to the lack of structural barriers. If you consent to having some of your sessions outdoors, please initial here: ____

- _____ GREATER GULF COAST COMMUNITY NETWORK: The Greater Gulf Coast Community Network is an alliance of community organizations in Brazoria and surrounding counties in Texas working to provide community care and limited health and educational support services to individuals in the community. Participants in the Network include organizations such as housing assistance, food banks, transportation service providers, respite care providers, health care providers and payers, philanthropic organizations and schools that work together as a Community Care Team to help provide for your basic needs. With your permission, community organizations can work together to collaborate and record the things you may need, such as food, nutritional care, clothing, housing assistance, job training, respite care, service coordination, and access to care. This is why we will ask for your permission to share your Protected Information within the Network. Protected Information is shared electronically among your Community Care Team on TAVConnect, a cloud-based data sharing platform hosted by TAVHealth. You will be asked to sign a separate consent form for TavHealth if our staff identifies a need for a referral for additional services.

- BUSINESS ASSOCIATES: In an effort to manage the business of our nonprofit agency, some of your personal health information may be shared with 3rd party vendors, who assist in the operations of our organization; i.e., accountants, attorneys, medical billing associates, scheduling practice management associates, technical support service providers, or other professionals for the purposes of doing business. Specific case descriptions that include process notes WILL NOT be disclosed to these business associates.

- THIRD PARTY PAYORS: As a nonprofit, our agency is dependent on outside funding to support service provision, which includes, but is not limited to: government funding, private donations, state funded Medicaid/Medicare programs, and/or contracting with private health care insurance companies. Disclosures during the course of your treatment for the purpose of collecting payment or fulfilling contract obligations may include releasing information to one of these 3rd party entities through written summary statements, phone consultations, or chart reviews. For all

insurance claims (excluding EAP services), one member of your family will receive a diagnosis even if/when the services are for marital and family therapy services. It is the policy of Counseling Connection to file insurance claims with one carrier. If you have a secondary policy, we are happy to provide you with the necessary documentation so you may file on your own. By signing this agreement, you consent to the exchange of information between our agency staff and your insurance provider for the purposes of authorizing, verifying and processing claims. In some instances, where government funding is involved, specific client numbers are used instead of your personal health information.

- COMMUNICATION: Customary business practices require communication between Counseling Connections for Change, Inc. and you, the patient. It is expected that clinical, support staff, and automated/contracted scheduling systems may contact you at the phone numbers, postal addresses, and email addresses provided. IF YOU DO NOT WANT TO BE CONTACTED BY ANY AGENT OR REPRESENTATIVE OF COUNSELING CONNECTIONS, IT IS YOUR RESPONSIBILITY TO PROVIDE A WRITTEN REQUEST TO THIS EFFECT.

- RISK OF HARM: Your safety and the safety of others is a priority. If any representative of our agency learns of or suspects risk of harm to you, another adult, a child, an elderly person, or a disabled individual, proper notifications will be made to insure safety, which may include local authorities. It is not the requirement of our agency staff to notify you in the event this report is made. This agreement provides that you are aware of the potential involvement of the Clinical Manager should risk of harm be identified.

- LEGAL PROCEEDINGS: **If you become involved in any legal proceeding that require our agency staff involvement, a retainer in the amount of $500 is required prior to engagement. All direct professional time, which includes, but is not limited to staff preparation, documentation review, report writing, and travel, will be billed at the rate of $150/hour, even if called to testify by an opposing party.** All rights to privacy are waived when court orders dictate. Should you or one of your family members become involved in a legal case that could impact this service agreement, it is your responsibility to notify your provider of the impending case, at which point the Clinical Manager and CEO of the corporation will be notified, and confidentiality is waived. If you or your family files any form of grievance or lawsuit against any agent or representative of Counseling Connections for Change, Inc., your rights to privacy are waived for the purposes of legal defense. By signing this form, you agree to these terms.

_____ ***Record requests and record keeping:*** Electronic Medical Records are maintained to insure the safekeeping of all your personal health information, and service documentation. These records constitute clinical and business records, and are the sole property of Counseling Connections for Change, Inc. Upon proper written request, copies of your records will be provided to healthcare provider and other clinical providers at no charge. Proper written requests shall include: 1) the name and date of birth of the client for which the records are being requested, 2) your name and relationship to the client, 3) the purpose of the request, 4) the name, address, and phone/fax #s of the provider, or entity for which the request is being made, and 5) your signature. Simply submit your request to the agency Maintainer of Records at Counseling Connections for Change, Inc., and allow 10 business days for processing the request.

Counseling Connections reserves the right to provide a summary of treatment in lieu of therapy notes, and also reserves the right to refuse to produce requested records under certain circumstances. At a record are maintained for seven years after the termination of services, and minor patient records are maintained for seven years after the 18th birthday.

Should your records be subpoenaed, or otherwise require retrieval and printing of said records, the cost is:

1. $25.00 for retrieval fees and copies of pages 1-10
2. For pages 11-60, the rate of $1.54 will be assessed
3. For pages 61-400, the rate per page will be set at $.76.
4. The rate of $.41 will cover any remaining copies.
5. The actual cost of mailing, shipping, or otherwise delivering will be added to these rates.

*****All outstanding balances must be paid prior to the release of any records, unless legally mandated otherwise.**

_____ **Fees *and billing practices:*** A Standard Fee Schedule and Financial Determination form is provided that outlines our posted rates. We accept all major mental health insurance plans including most Medicaid managed care plans, and Tri-care for our military families. We also accept all forms of payment (cash and credit), and offer a sliding scale option when our standard rates are cost prohibitive. Our desire, as a 501(c)(3), nonprofit Christian counseling center, is to serve your counseling needs regardless of your ability to pay, so if you are in need of financial assistance, please complete the Sliding Scale application, and turn it into the scheduling coordinator at the front desk.

If you are using your insurance to cover any portion of your mental healthcare, you are still responsible for all services rendered regardless of whether or not the insurance company pays. It is your responsibility to notify the front desk staff if your insurance carrier has changed. All outstanding balances (those exceeding 90 days after the date of service) will be billed directly to you. Counseling Connections reserves the right to enlist the services of a 3rd party collection agency if the outstanding bill exceeds $500. By signing this agreement, you are acknowledging that you are responsible for payment of all charges regardless of whether or not reimbursed by the insurance company.

Credit Card Authorization Agreement

As a convenience to you and your family, Counseling Connections for Change, Inc. accepts credit/debit cards as a form of payment. Many of our clients use this form to set up automatic payments for scheduled therapy sessions, online or phone sessions, unexpected late cancellation fees that fall within 48 hours, or to simply expedite the check-in experience. All credit/debit card information is securely stored in your health record.

Name of Card Holder (as name appears on the card): _____

Type: ❑ Visa ❑ MasterCard #_____ Expiration: _____

Verification/Security Code (3-digit code on back of card by signature line): _____

Billing Address: _____

City: _____ State: _____ Zip: _____

❑ By signing below, I am authorizing Counseling Connections for Change, Inc. to bill my credit/debit card at the established rate posted on the Standard Feed Schedule for services rendered, and I agree to not dispute charges

("charge back") for sessions I have received or appointments I have missed according to the above policy.

Signature: _____ Date: _____

Print Name: _____

We would like to thank the person who referred you to Counseling Connections for Change, Inc. By providing the name below, you are authorizing us to send a thank you note to the referral source.

The name of the person who referred you: _____

The above-mentioned topics have been explained to me in a language that is understandable to me, and I have had my questions answered. I understand my consent for services is voluntary and may be withdrawn at any time. I am in agreement with the services outlined in this document, and consent to begin treatment as shown by my signature below.

_____ _____

Client Name Date

_____ _____

Client signature Date

I have explained the content within this document as well as provide ample opportunity to ask questions. I have answered all of the questions to the best of my ability.

_____ _____

Provider signature Date