# Ronda Kimball, MS, LPC Intern,

# CMHIMP, CTP

# Supervised by Tamara Allen Bush, LPC-S

# Joyful Restoration Wellness

# 2214 Emery St., Ste. 510

# Denton, TX 76201

# 817-771-2728, [innerlife122@gmail.com](mailto:innerlife122@gmail.com) innerlife122.wixsite.com

CLIENT INFORMATION AND CONSENT

Welcome! It is my desire to insure that your participation in counseling is a productive and satisfying one. In order to facilitate a therapeutic relationship, we have set forth certain information, which will enable you to make an informed consent to counseling.

# Counselor

I am a graduate of Hope International University, I completed my Master Degree in Counseling. I use an approach to counseling which takes into account the psychological, biological, social, and spiritual dimensions of the client. I strive to establish and maintain a relationship with you, the client, characterized by equality and cooperation that allows you *to* explore needs, perspectives and goals. I will seek to offer appropriate suggestions and vehicles to encourage the achievement of your goals.

# Counseling Services and Risks of Counseling

The number of sessions needed depends on many factors and is different for every client. The client understands it is up to the client and the counselor to determine the number and frequency of sessions necessary and that this may change throughout the course of counseling.

It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. Often, growth cannot occur until you experience and confront issues that may induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both of our parts, and the realization that you are responsible for your own lifestyle choices/ changes that may result from therapy. You have the right to refuse or negotiate modification of any technique that concerns you. Possible positive or negative effects of entering or not entering counseling and/or using or not using certain techniques may be discussed at any time during the relationship at the initiation of either you or me. You may bring other family members to a counseling session if you feel it would be helpful or if I recommend it and you agree. However, this must be discussed and agreed upon before the individual joins you in session.

Client Initials

# Relationship

Your relationship with me is a professional and therapeutic relationship. In order to preserve this relationship, it is important that I limit other types of relationships with you. Personal and/or business relationships may undermine the effectiveness of the counseling relationship and are unethical. Out of respect for your HIPPA privacy, I will not initiate conversation with you in a social setting and will be brief if you initiate contact.

Also, the counselor will not enter into any non-counseling business or personal relationships with the client or the client's family that could be harmful to the counseling relationship.

# Goals, Purposes, and Techniques of Therapy

I primarily use Cognitive Behavioral techniques in therapy. However, there may be alternative ways to effectively treat the problems you are experiencing which may be used. It is important for you to discuss any questions you may have regarding the treatment recommended by the counselor and to have input into setting the goals of your therapy. I also believe that prayer, Bible study, and the power of the Holy Spirit within an individual are among the resources that can be applied, if the client should choose. If the client wishes not to have these methods as a part of counseling, the client will inform the counselor. The counselor and client will discuss goals during the initial session and throughout therapy. As therapy progresses, these goals may change.

# Appointments & Cancellations

Appointments are made by calling **817-771-2728** Monday through Thursday between the hours of 9:00 a.m. and 7:00 p.m. and Friday 12:00 pm to 5:00 pm. Therapy sessions are approximately 50 minutes in length but may be longer if agreed upon by counselor and client. As a client, you may end the relationship at any point. We request that the termination include one week's notice in writing.

Cancellations should be received as soon as you are aware that you will miss your scheduled appointment. Due to high demand for counseling services, we require 24 hours' notice for cancellation of an appointment, which makes an appointment possible for someone else. A cancellation fee equal to your session fee, will be charged for missed appointments or for appointments cancelled with less than 24 hours' notice. Payment for missed/late appointments will be due at the next scheduled appointment. Cancellations may be made 24 hours prior to the scheduled appointment by phone to 817-771-2728 during business hours or by emailing your counselor at innerlife122@gmail.com.

Client Initials

# Phone Consultations

Phone consultations with clients or parents of minor clients will be free of charge for emergencies or other calls lasting less than 10 minutes in length. If a phone consultation lasts longer than 10 minutes, it is office policy that we schedule a session in order to discuss the issue. If you wish to continue the conversation more than 10 minutes, you will be charged $20 for up to 20 minutes and the full fee of a session for phone consults lasting longer than 20 minutes. Fee is to be paid to our office at the time of your next session.

# E-mail Communication

I understand that if I choose, I may contact the counselor by e-mail between sessions. I understand that my counselor may respond, but will be brief. I understand that there are risks associated with communicating by email. However, I also understand that if at any point throughout the counseling process my counselor believes that I am using e­-mail to replace face-to-face counseling or am using e-mail too frequently between sessions, my counselor has the right to set limits on e-mail communication and/or deny my privilege to have further e-mail communication with the counselor.

# Payment for Services

The fee for a counseling session will be $90.00, unless otherwise approved ahead of time. All fees are to be paid at the time of service by check, cash, Mastercard, Visa, Discover, American Express and some Health Savings Accounts. If you request, you will be provided with a receipt.

By signing this document you consent to allow our office manager, or another appointed staff member, to have knowledge of your identity when paying. They understand the necessity of maintaining strict confidentiality of these records and agree to maintain your records under strict confidentiality guidelines per HIPPA.

No insurance will be filed by the counselor. If the client wishes to file out of network benefits with their insurance, the client will be responsible for filing all documents. In this case, the client will be responsible for paying in full at the time the services are rendered. The counselor will then supply an appropriate receipt at the time of the client's next session. However, no guarantees are made that the client will be reimbursed by their insurance company.

Client Initials

# Legal Actions & Fees

The client agrees to hold Counselor and her heirs harmless for any alleged or perceived controversies, damages or claims arising out of the rendering of services agreed upon herein. However, in the event that the client disregards the terms of this agreement and initiates legal action against the counselor for whatever reason, and counselor must testify in defense of or otherwise defend self, confidentiality of information revealed by client at any time cannot be assumed. It is understood that Counselor will offer whatever information is deemed appropriate and necessary to defend herself against any legal action initiated by the client or as a result of client's actions. Complaints against the counselor can be made to Tamara Allen Bush LPC-S at 817-713-7223.

Although it is our goal to protect the confidentiality of your records, there may be a time when disclosure of your records or testimony will be compelled by law. Confidentiality

and exceptions to confidentiality are discussed below. In the event that disclosure of your records or my testimony are requested by you or required by law, **you will be responsible for and shall pay the costs involved in preparing for and giving testimony.** Fees for court appearances or consults with lawyers will be $2000 per day to cover the cost of the counselor's time away from clients and office responsibilities. If the consultation or court appearance takes place off site, the hour will start when the counselor leaves her office and will end when she returns to her office. Such payments are to be made at the time the services are rendered. We may require a deposit for anticipated court appearances and preparation.

In accordance with state standards, we will follow the following fee schedule for copies of mental health records. These fees are to be paid by the client before the records are released unless there is an emergency situation:

* A basic retrieval and processing fee of $30, which includes the cost of the first 10 pages copied.

o Pages 11 to 400 will be .25 cents per page

«» The actual cost of mailing, shipping, or delivering the copies

* No fee will be charged for billing records or the first copy of mental health records that are requested for disability purposes.

Charges for copies for other purposes, such as copies of decrees or other documents that are required to be in the file that the client does not provide us with a copy of or copies of other documents the client wishes to be stored in the file, will be charged .25 cents per page, payable at the time the copy is made.

Client Initials

# Confidentiality

Discussions between a counselor and a client are confidential per the HIPPA Privacy and Confidentiality Act. No information will be released without the client's written consent unless mandated or allowed by law. We are legally required to break confidentiality in the event of child abuse or abuse of the disabled or elderly. Confidentiality will be broken if in the counselor's judgment you become a danger to yourself or others. As necessary, client treatment issues and needs will be shared with my clinical supervisor and may be shared with the directors of the counseling center or other counseling professionals in a consultation manner for the purpose of supervision and enhancing your progress. For further information, *review* the Notice of Privacy Practices furnished to you by your counselor in conjunction with this Client Information and Consent document. If you have any questions regarding confidentiality, you should bring them to the attention of the counselor when you can both discuss this matter further.

By signing this information and consent form, you are giving your consent to the undersigned counselor to share confidential information with all persons mandated by

law as well as her supervisor, and you are also releasing and holding harmless the undersigned counselor from any departure from your right of confidentiality that may result.

In the event that the undersigned counselor reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the counselor to inform the following person in order to help ensure my safety:

Name Relationship: \_ \_ \_ \_

Phone -- - - - - - - - - - - - - -

Client's Initials: \_ \_ \_ \_

This information is to be provided at my request for use by said persons only to prevent harm to myself or another person. This authorization shall expire upon the termination of my therapy with the undersigned counselor.

I acknowledge that I *have* the right to revoke this authorization in writing at any time to the extent the undersigned counselor has not taken action in reliance on this authorization. I further acknowledge that *even* if I revoke this authorization, the use and disclosure of my protected health information could possibly still be permitted by law as indicated in the copy of that Notice of Privacy Practices of the undersigned counselor that I have received and reviewed. I acknowledge that I have been advised by the undersigned counselor of the potential of the re-disclosure of my protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule. I further acknowledge that the treatment provided to me by the undersigned counselor was conditioned on my providing authorization.

Client Initials

# Right to View Files

I have the right to copies of my entire file but acknowledge some information may not be in my best interest to review. In the event my counselor, in the exercise of her professional judgment, determines that information in my file may be injurious to me, I waive my right to obtain such potentially injurious information and release my counselor from any and all claims, damages, and causes of action that I suffer or could assert for her refusal to provide me with the information requested. The counselor's discretion shall control.

# After-Hours Emergencies

If you need to contact your counselor during non -business hours, please leave a message on her office voicemail (817-771-2728) or send an e-mail with a brief message. The counselor will respond on the next business day. If you have an emergency which requires immediate action, call 911, the county Crisis/Suicide number at 1-866-672-5100 or go to your local emergency room.

# Counselor Incapacity or Death

I acknowledge that, in the event that the undersigned counselor becomes incapacitated or dies, it will become necessary for another counselor to have access to my files and records. All files generated with regard to my care will be maintained in the counseling offices at White Stone Counseling under the care of Tamara Allen Bush, LPC-S. By signing this information and consent form, I give my consent to allow Tamara Allen Bush, LPC-S to have access to my file and records and provide me with copies upon request or to deliver them to a mental health professional of my choice.

Client Initials

# Consent to Treatment

I voluntarily agree to receive assessment, care, treatment, or services, and authorize the undersigned counselor to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned counselor at any time. If I terminate services, I acknowledge that I am free to choose other agencies for treatment and that I may get a list of local referral resources from my counselor. Additionally, based on the judgment of my counselor, I may be referred to an outside source.

I also understand that my services may be terminated if I become violent, verbally or physically aggressive, or act in a sexually inappropriate way toward other clients, guests, or staff; if I engage in illegal activity on the property; or if I fail to attend three appointments without appropriate excuse.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client/Legal

Guardian Date As witnessed by:

Ronda Kimball, LPC Intern

Supervised by Tamara Allen Bush

Client Demographic Information

Please fill your current demographic information. By signing this document you are consenting to have your demographic information stored in our HIPAA compliant online portal and consenting to receive appointment reminders by the method of your choice.

Name: Birth Date: \_ Address:

Email:

Phone Number:

**May we contact you by phone: Y N May we leave a message: Y N May we contact you by email: Y N May we contact you by mail: Y N**

**Please indicate whether you would like to receive appointment reminders by:**

Circle one: Text Message / Email / I wish to not receive appointment reminders

Client/Guardian Signature:, \_ Date: \_

**Notice of Privacy Practices Client Consent Form**

I understand that as part of my health care, the undersigned counselor originates and maintains health records describing my health history, symptoms, evaluations and test results, diagnosis, treatment, psychotherapy notes, and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other health care providers and other routine health care operations such as assessing quality and reviewing competence of health care professionals. I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been advised in the Notice of Privacy Practices that I have a right to copies of my entire file but acknowledge some information may not be in my best interest to review. In the event my counselor, in the exercise of his/her professional judgment, determines that information in my file may be injurious to me, I waive my right to obtain this information and release my counselor from any and all claims, damages, and causes of action that I suffer or could assert for his/her refusal to provide me with the information requested. The counselor's discretion shall control.

The *Notice of Privacy Practices* for this office provides specific information and a description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and have been given the opportunity to review the notice prior to signing this consent.

I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or health care any time in writing except to the extent that action has already been taken in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure of my personal health information.

Therapist response: Agree to restriction/ Do not agree to restriction

Signature of Client or Legal Representative

Signature of Client or Legal Representative

Date:

Date:

Witnessed: \_ Date:

**For Office Use Only:**

I attempted to obtain written acknowledgement of the privacy practices, but acknowledgement could not be obtained because:

□

Individual refused to sign

Emergency situation prevented us from signing

* Communication barriers
* Other: Explain below