Heights Anxiety and Depression Center

No matter how hard the past, you can always begin again.

Informed Consent

Thank you for choosing Heights Anxiety and Depression Center for your behavioral health needs.

Scheduling your first appointment is often a difficult decision. Congratulations on taking this step. We look forward to collaborating with you.

Heights Anxiety and Depression Center offers a wide range of therapeutic approaches and psychotherapy services to adolescents and adults. Clinicians at Heights Anxiety and Depression Center are approachable and specialists in providing therapeutic services.

CONFIDENTIALITY Information provided by you in this counseling/psychotherapy relationship is strictly confidential and will not be divulged except:

1. Information about the abuse, neglect or exploitation of a minor child, elderly or disabled person must be reported to the proper authorities as required by Texas law.
2. Information indicating an eminent physical threat of violence to yourself or another person may include reporting to the appropriate authorities.
3. When you provide written authorization allowing disclosure.
4. Certain court orders can require disclosure of some information.
5. Sometimes consultation with another clinician may be necessary. When this occurs, reasonable efforts will be taken to protect your identity.

All patients have the right to be informed of the goals and purposes, techniques, procedures, limitations, possible risks, and the benefits of services to be performed. Goals of treatment and procedures to be used will be agreed upon by the patient and the clinician. This is usually done in the first or second session, after the clinician has obtained an extensive psychosocial history from the patient. This history enables the clinician and the patient to complete the most effective treatment plan and set appropriate goals for therapy.

It is impossible to guarantee any specific results regarding counseling and psychotherapy outcomes. Many variables, including the quality of collaboration between the patient and the clinician, compliance with therapeutic recommendations, and the patient's motivation to reach desired outcomes, affect the result.

Please be assured our services are rendered in a professional manner consistent with accepted ethical standards. Our clinicians subscribe to the ethical standards of the American Counseling Association and the National Association of Social Workers, respectively.

A therapeutic relationship strives to explore and resolve difficult life issues. As people become more accepting of themselves, they are more capable of finding happiness and contentment in their lives. Self- awareness and self-acceptance are goals that sometimes take a long time to achieve. While some patients' may need only a few therapy sessions, others may require months or even years of therapy. Patients are in complete control and may terminate the therapeutic relationship at any point for any reason, and our clinicians will be supportive of that decision.

Although therapy sessions will be intimate, it is important our patients understand we have a professional, rather than personal, relationship. Contact with the clinician will be limited to the paid session, or emergencies after-hours. Please do not invite your clinician to social gatherings, offer gifts, or ask them to relate to you in any way outside the therapy session. You will be best served if the relationship remains strictly professional and if the sessions concentrate exclusively on your concerns. You will learn a great deal about your clinician as you work together during the therapeutic experience. However, it is important for the patient to remember they are experiencing the clinician solely in their professional role.

Notice of Privacy and Confidentiality: Privacy and confidentiality is a cornerstone of psychological treatment. Discussions between the clinician and the client are confidential. No information will be released without your written consent, unless mandated by law.

Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; criminal prosecutions; child custody cases; suits in which the mental health of a party is an issue; fee disputes between the provider and the client; a negligence suit brought by the client against the psychotherapist; or the filing of a complaint with the state licensing board or other regulatory body.

If you have any questions about confidentiality, you should bring them to our attention so that we can discuss the matter further. By signing this information and consent form, you are giving your consent to your clinician to share confidential information with all persons mandated by law and with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding your clinician harmless from any departure from the right of confidentiality that may result.

Psychotherapy notes will have a high level of protection under the HIPAA (Health Insurance Portability and Accountability Act of 1996) privacy regulations that took effect in April 2003. Then their contents may not be divulged without your specific authorization, which is not permitted to be required as a condition of insurance coverage. Other exceptions to the special protection of psychotherapy notes under law are to prevent harm to the patient or others, for the provider's defense in legal actions, regulatory actions, regulatory oversight of the provider's professional status, confidential supervision in training situations, or investigation by a medical examiner in the

event of a patient's death. We serve as the Privacy Official and contact person as required by HIPAA. We keep electronic medical records and any electronic files are password protected to protect your information. Records will be retained as required by law. If you give consent for the release of medical information from your general medical record, in compliance with HIPAA, we will disclose only the minimum amount of information necessary to serve the purpose for which the request has been made. The American Psychiatric Association has defined guidelines for minimum disclosure. Also, under HIPAA regulations, we will provide you with a notice of privacy practices. We must ask you to sign a HIPAA release of information and provide you with notice of privacy practices. We will be very happy to discuss any part of this notice with you at your request at any time.

Confidentiality and Third-Party Payers: You should realize that any information given at your request to an insurance company or managed care company is thereafter beyond our control. Health insurance companies sometimes give information to the medical information bureau, which may affect your future eligibility for life, disability, or other insurance. Some employers obtain identifiable data from administrators of their health insurance. Medicare and other insurance plans have the right to inspect the medical records of subscribers who file claims. In our experience, such events are rare, and we would resist them to the greatest extent legally possible, but it is important that you know that this can happen if you choose to file claims for insurance or Medicare payments. However, the best safeguard for your privacy is not to involve third parties in your treatment. Other breaches of privacy could occur in extreme situations that are beyond our control and are required by law or are essential to prevent imminent serious harm.

Initial Treatment Plan: By signing this information and consent form below, I agree to the initial treatment plan below. Usually the initial treatment plan begins only with a psychiatric evaluation unless otherwise stated below.

Consent to Treatment: I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the undersigned provider, Heights Anxiety and Depression Center, 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. By signing this treatment information and consent form, I the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Many opportunities have been offered to me to ask questions and seek clarification of anything unclear to me.

Treatment Information and Consent Form

Nature of the Therapeutic Relationship: Your plan of care will involve psychotherapy and requires an active engagement on your part to talk about your life openly and honestly. If difficulties arise, we hope that we can work together to resolve them as quickly as possible.

Your relationship with your clinician is a professional and therapeutic relationship personal and/or business relationships undermine the effectiveness of the therapeutic relationship.

Client Signature	Client Printed Name	Date

Representative Signature	Representative Printed Name	Date

Therapist Signature	Therapist Printed Name	Date

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Credit Card Authorization

THIS FORM, ONCE COMPLETED, IS FILED IN A HIPAA compliant secured server with ACCESS LIMITED TO ONLY THE PRACTICE MANAGER

Financial Policy: We accept most insurance. If we are not on a specific insurance panel and considered out of network, you will be financially responsible for the visit. Payment is due at the time of service. We accept any major credit card and personal checks.

No Show Fees Policy /Psychotherapy late cancellation/no show appointments: $60

A block of time is reserved for your appointment. If you must cancel the appointment for any reason, please give us 24-business hrs. of advanced notice. If you fail to give us the advanced notice to cancel your appointment, then we will charge the following amount: $60. Please be advised that if you miss or no show, to more than 4 appointments in one calendar year, then we reserve the right to refuse providing service at our clinic and will encourage you to follow-up with a different provider in the community. Upon termination of therapy the clinician will assist the client in finding other services or another therapist, when necessary. Closure is an important part of the therapeutic relationship for both the patient and the clinician. For this reason, we encourage a termination appointment for all patients that are ending individual therapy.

Fee for Service:

- Co-payments and/or co-insurances elected for payment by credit card will be charged to card on file below.
- The balance of charges for services rendered, but not paid by the insurance company within (30) days from the date of service will be collected from the card on file below.
- The $60.00 no-show/missed appointment fee for failing to notify the clinic 24-hours prior to the scheduled appointment. (This cannot be billed to the insurance company)
- Telephone calls with the clinician outside the appointed time which last longer than 10-minutes would be charged at a rate of $30 per 15-minute increment.
- E-mail responses from the clinician requiring more than 10-minutes to compose would be charged at a rate of $30 per 15-minute increment.
- Copying/scanning of your file (for the purposes of sharing with your attorney, CPS, school, employer, etc.) at a rate of $20.00 for first 25 pages.

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- Completion/Preparation of Reports or Letters at a rate of $120.00 per hour, with a $60.00 minimum.
- Legal testimony at a rate of $225.00 per hour (to include travel).
- Private Pay Rate:
  - Individual 60-minute session $120 per hour
  - Family 60-minute session $140 per hour

Credit Card Policy: Your credit card will be stored in our HIPPA compliant secured servers and will be used to charge your account towards any pending payments including but not limited to – Co-Pays, Co- insurances, Office visits, No- Show fees. By signing this consent form, you agree to give Heights Anxiety and Depression Center, INC the permission to charge your credit card remotely for any outstanding payments.

Client Name	Client Date of Birth
Credit Card Number	
CVV Code (Front of card for AMEX)	**Expiration Date**
Name as it appears on Card	
Billing address associated with the credit card	State and Zip
Cardholders Signature	Date

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Email Consent

Heights Anxiety and Depression Center will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined previously, Heights Anxiety and Depression Center cannot guarantee the security and privacy of e-mail communication and will not be liable for improper disclosure of confidential information that is NOT caused by the intentional misconduct of Heights Anxiety and Depression Center, our employees, agents or representative. Thus, the patient must consent to the use of e-mail for the patient information.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of e-mail, third-parties may have access to electronic communication. When communicating from your place of employment, some employers consider e-mail corporate property and your messages may be monitored. Additionally, you should be aware that although messages are addressed to your clinician, administrative staff and/or other clinicians may have access to this information.

If you provide an e-mail address to us or initiate e-mail contact with us, doing so constitutes your authorization for us to communicate with you via e-mail to your indicated return e-mail address.

Your signature below indicates your understanding of the potential privacy limitations and the guidelines of communication via e-mail with this clinic and its employees. I understand the risks associated with communication via e-mail, and consent to the conditions herein. Additionally, I agree to the instructions outlined herein, as well as any other instructions a mental health professional may impose to communicate with patients via e-mail.

Client/Legal Representative Signature	Client/Legal Representative Printed Name	Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, text or emails, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal guardian.

2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made, they will be disclosed to you or your legal representative unless disclosure increases risk of further harm.

3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in Sections 1 and Sections 2.

4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at any time. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request.

5. You may request corrections to your records.

6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.

7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request review of the denial. A review will be conducted by another licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.

8. You may request that we restrict uses and disclosures outlined in Section 1. However, we are not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, we will be

bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. We may also revoke such restrictions, but information gathered while required by law or in an emergency. We may also revoke such restrictions, but information gathered while the restriction was in place will remain restricted by such an agreement. For more information see: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

9. If you wish to complain about privacy related issues you may contact the U.S. Department of Health and Human Services 200 Independence Avenue, S.W.

Room 509F HHH Bldg. Washington, D.C. 20201. We will not retaliate or take action against you for filing a complaint.

10. This agreement may be modified or amended as required by law or in the course of health care operations.

I HAVE READ AND UNDERSTOOD THIS PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEATLH CARE INFORMATION.

Client or Legal Representative Name	Client or Legal Representative Signature	Date