New Life & Love Counseling 17890 Blanco Rd Suite 306 San Antonio, TX 78232 210.725.1389

Colleen Ann McDonald, MA, LPC

Licensed Professional Counselor

OUTPATIENT SERVICES CONTRACT

COUNSELING SERVICES

Welcome to my practice. This document contains important information about professional services and business policies. Please read it carefully and jot down any questions you have so they can be discussed. When you sign this document, it will represent an agreement between us.

Counseling is not easily described in general statements but depends on the counselor, client and the particular problems presented. Counseling calls for an interaction between therapist and client and for therapy to be successful, clients are to employ concepts, strategies and techniques discussed during sessions. Therapy can have some unpleasant aspects that may be coupled with uncomfortable feelings. However, these experiences often lead to improved relationships, solutions to problems, and a reduction in feelings of distress.

COUNSELING SESSIONS

Issues and concerns are evaluated during the first session and continue throughout the therapeutic process. During this time, it can be determined if the client/therapist relationship will be able to generate the desired treatment goals. Counseling sessions are 45-60 minutes and begin on a weekly or bi-weekly schedule and are then scheduled less frequently based on progress. The client is responsible for scheduling their sessions and canceling them if they are unable to attend. **We request a twenty-four hours notice or a $50.00 fee will be assessed for the missed session. A session missed without notification will be charged the full session rate.** This fee cannot be billed to your insurance and will be charged to your credit card on file the day of your missed session. Repetitive late cancellations, no shows, or cancellations in general will result in referral to another therapist.

PROFESSIONAL FEES AND BILLING SERVICES

The fee for the initial therapy session which includes the initial evaluation and initial treatment planning is $135.00. Subsequent individual therapy sessions are $120.00 and family therapy sessions are $120.00. Payment is expected from the client at the time of service or from the insurance company. Insurance is to be activated before scheduled therapy. The billing person works with the client concerning pre-certification and explanation of benefits. Other professional services such as preparation of documents or treatment summaries and attendance at ARD meetings will be billed at the same rate as counseling.

PLEASE NOTE: The therapist does not participate in legal proceedings but will refer the client to another clinician or entity that deals with legal issues. In the event that proceedings do arise, the fee for court ordered services and/or subpoena is $2000 for the first day, to be paid in advance, followed by $1500 for each additional day of legal proceedings.

Please initial to indicate that you understand the highlighted policy:___________

CONTACTING ME

Confidential voicemail is available 24 hours a day. The therapist is usually in session and not available by telephone. Please leave a message on the voice mail. Every effort will be made to return all calls as soon as possible. In case of an urgent need or emergency after hours, the client is encouraged to call 911 or go the nearest emergency room. The therapist is out of the office on Mondays and Tuesdays. Please limit texting to scheduling issues.

PROFESSIONAL RECORDS

The laws and standards for counseling in Texas require the therapist to keep treatment records. These records are confidential and will not be released to anyone without the client's consent. Please be aware that the client may choose not to release these records if they can be emotionally or legally damaging. The therapist will make these records available to another mental or medical health professional at the client's request.

MINORS

The therapist is committed to providing confidentiality for adolescent clients. The therapist will provide generalized (not specific) information about the therapy sessions to the parents/guardians of the client. The therapist will provide more specific information as approved by the adolescent client. Parents of children in therapy are involved in the process and participate in formulating the treatment goals.
PLEASE NOTE: The therapist will ask for help from a parent or guardian if the client is at risk of seriously harming him/her self or someone else. There are also other situations that may require the therapist to release the records of minors.

CONFIDENTIALITY

The privacy of all communications between a client and therapist is protected by law, and the therapist can only release information about their work with the client's written permission. However, there are exceptions:

- The therapist is legally obligated to take action to protect a child, elderly person or disabled person from abuse by reporting the action to the appropriate state agency.
- The therapist will contact family members or others if there is a threat of serious self harm or harm to another. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. In these cases, a more intensive treatment plan will be developed by the therapist, the client and their family members.
- The therapist is legally obligated to release the client's therapy notes (or a summation) if requested by a court of law.

On occasion the therapist may need to consult with other professionals about a case. During these consultations, cases are discussed without revealing the identity of the client. The consultant is also legally bound to keep all information confidential.

Questions or concerns about confidentiality can be discussed with the therapist

FEDERAL HEALTH INSURANCE PORTABLITIY AND ACCOUNTABILITY ACT (HIPAA)

This law insures the confidentiality of all electronic transmission of information about the client. Whenever the therapist transmits information about the client electronically (i.e. sending bills or faxing information), it will be done with special safeguards to insure confidentiality. If the client elects to communicate with the therapist by email, please be aware that email is not completely confidential. Any email the therapist receives from the client and any responses sent, will be printed out and kept in the client's treatment record.

Your signature indicates that you have read this document and consent to treatment. This will serve as a contract between you and the provider:

____ ____________________
Client Signature Date

____ ____________________
Client Printed Name Date

If client is under 18, parent/guardian consent is needed.

____ ____________________
Parent/Guardian Signature Date

____ ____________________
Parent/Guardian Printed Name Date

Coordination of Care between Health Care Providers / Release of Information

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. **This form will allow your behavioral health provider to share protected health information (PHI) with your other provider or person you designate below**. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires twelve (12) months from the date of my signature below unless otherwise stated herein.**

__Colleen Ann McDonald, MA, LPC________is authorized to release protected health information related to the
(Provider Name-Please Print)

evaluation and treatment of ___________________________________ ______ /______ /_______.
(Member Name) (Date of Birth – MM/DD/YYYY)

PCP Name: ______________________________________ PCP Phone/Fax: ____________________________

PCP Address: ____

BH Provider/Psychiatrist Name: _____________________________ BH Provider Phone/Fax: _______________

BH Provider Address: ____

Other Name: _______________________________________ Other Phone/Fax:__________________________

Other Address: ____

____
(Signature of Patient, Parent, Guardian or Authorized Representative) (Date)

If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)

I authorize Colleen Ann McDonald to use my health information to activate my insurance benefit program. The purpose will be to process claims for insurance payment. I also understand my privacy will be respected and procedures will follow the HIPAA Privacy Notice that I have received.

____ ____________

Client Signature Date

____ ____________

Parent/Guardian Signature (if client is under 18) Date

CREDIT CARD AUTHORIZATION FORM

Your signature, below, authorizes us to review this information and deduct fees from the credit card below in the case of a cancellation less than 24 hours or in the case of a session missed without notification, and for payment of patient out-of-pocket costs.

We accept all major credit cards at this time.
A Health Savings account (HSA) or employee paid benefits account card may not be used for cancelation fees. If you would like to use an HSA to cover patient out-of-pocket costs, please request an additional form.

CARD INFORMATION

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ Other __________

Name on Card: ____

Account Number: ____

Expiration Date: ____________ CVV Code (on back): ___________

Billing Zip Code: ____________

If anyone other than the cardholder is authorized to use this credit card, please have him or her print and sign his or her name:

Print Name: ____

Signature: ____

Date: ____________________

I,____________________, authorize Colleen McDonald, LPC, to charge the credit card above for agreed upon fees. I understand that my card will be charged on the day of my scheduled appointment if I cancel last minute (less than 24hrs before) or no show (missed without notification). I understand my card will be charged $30.00 for a cancellation and $50.00 for a no show. I understand this information will be saved to file for future transactions.

Signature: ____

Date: ____________________