Woodlands Family Institute, P.C.

Josh Parham, MA, LPC-S

INFORMATION, CONSENT, AND POLICIES

I am honored you have asked me to help you by providing counseling services. I will do everything I can to make this experience as meaning and fruitful as possible. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I have a Bachelor's Degree in Psychology, and a Master's Degree in Clinical Psychology. I have been a Licensed Professional Counselor since 2005. I believe that no matter how difficult a person's circumstance may be, it is possible to produce meaningful changes. Sometimes this takes a long time to achieve. While some clients need only a few sessions to reach their goals, others may require months or even years. As a client, you are in complete control and may end our professional relationship at any point. I will be supportive of that decision. Ultimately, my job is to work myself out of a job, so that you feel confident to carry on without my intervention.

This process is a partnership between you and me to work on areas of dissatisfaction in your life or to assist you with life goals. For this to be most effective, it is important that you take an active role in the process. This involves keeping scheduled appointments, being forthright about your issues and goals, and openly discussing the process with me. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. While counseling or psychotherapy can benefit most people, the process is not always helpful. Sessions can evoke strong emotions and sometimes influence unanticipated changes in one's behavior. It is important that you discuss with me any questions or discomfort you may have during the process. I may be able to help you understand the experience or use a different approach that may be more satisfying.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you arrange with me. It may be confusing and counter-productive for me to accept gifts or be invited to social gatherings. So please do not ask me to relate to you in any way other than in the professional context of our sessions. I want your sessions to be as safe and secure as possible so that we can concentrate exclusively on your concerns. You are best served by experiencing me in my professional role. If at any time you are dissatisfied with my services, please let me know.

Children can be joyful and energetic, but with respect to the concerns which brought you to me, I request that you obtain a sitter for children not receiving treatment so that our full attention can be devoted to your priorities.

I assure you that our work will be conducted in a conscientious manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results for you.

OFFICE POLICIES

FEE SCHEDULE:

Standard rate: $150.00 per standard 45 minute session. Cash or personal checks are accepted. This rate also applies to other professional services, prorated on the basis of $150.00 per hour ($3.33 per minute). These services include, but are not limited to, phone calls, insurance reports, third-party consultations, and correspondence.

PAYMENT POLICY:

Payment is due in full at time of service. Please make out your check before the session begins. Checks should be made out to: Woodlands Family Institute (or WFI). Cash and Visa or MasterCard are also accepted. It is not my policy to carry balances forward. I expect balances for "forgotten checkbooks" or forgotten appointments to be made up promptly or by the next scheduled appointment at the latest. If an outstanding balance accrues, you will be billed on the first of the month assessed a 2% finance charge, compounded monthly. There is $10.00 rebilling fee for every statement sent out after the first billing. There is also a $25.oo fee for each check returned for insufficient funds. After 90 days with no payments or effort to arrange payment, accounts will be turned over to a collection agency and will impact your credit rating.

_____Initials indicating you understand payment policy and fees

Legal Testimony:
Please be advised that I **do not** provide consultation, evaluation, or legal expert testimony in child custody, child visitation, or molestation cases. Similarly, I do not consider my practice to include expert testimonials. However, should my opinion be so ordered, fees will be charged at the rate of $500 per hour, portal to portal. This fee will apply to depositions or interrogatories as well. Record review, consultation with clients, litigants, attorneys (in person or via phone or email), reports, waiting at court, or any other service provided will be charged at the rate of $140 per hour or prorated accordingly. These fees are **payable in advance.**

INSURANCE:
I am not a participating provider for any insurance carriers. We will provide you with an insurance-ready receipt that you can use to file for out of network benefits. Reimbursement will depend on your insurance plan.

OFFICE HOURS:
I currently see clients Monday through Thursday by appointment only.

CANCELLATIONS:
Since the scheduling of an appointment involves the reservation of time specifically for you, 24 hours advance notice for any cancelled appointments will not be charged. If you are unable to meet this time schedule, but if I am able to assign your appointment time to another client, you will not be charged. If the session cannot be filled, or if you are a "no show," you will be charged the full rate of the session. Please note that insurance companies do not reimburse for missed appointments. **Please call the WFI for cancellations, as email is not monitored daily for cancellations.**

_____Initials indicating you understand cancellation policy

EMERGENCIES:
It is assumed that outpatient clients are self-responsible, autonomous, and not in need of day-to-day supervision. Outpatient clinicians cannot assume responsibilities for client's day-to-day functioning, as can agencies or inpatient hospital settings. Nevertheless, in the event that an emergency occurs, leave a message at 281-363-4220 making sure to state that your call is an emergency. I will respond to your call as promptly as possible. If I am unable to respond quickly enough, please call 911 or go to your local emergency room.

CONFIDENTIALITY:

The law protects the privacy of all communications between a client and psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by federal and state law. Your signature on the Acknowledgement form provides consent for those activities, as follows:

Occasionally, it is helpful to consult other health and mental health professionals about a client. During a consultation, every effort is made to avoid revealing a client's identity. Any other professionals consulted are also legally bound to keep the information confidential. These consultations are very commonplace and routine and may not be ordinarily mentioned in our sessions, unless it seems important to our work together. If you would prefer this be handled differently, please let me know.

I will keep confidential anything you say to me, with the following exceptions: a) you direct me to tell someone else; b)I determine that you are a danger to yourself or others; c) I am ordered by a court or regulatory body to disclose information; d) you disclose abuse or neglect of children, the elderly, or disable persons; e) the need to release information to other professionals involved in your treatment; f) in proceedings in which a claim is made about one's physical, emotional, or mental condition; g) when disclosure is relevant in any suit affecting the parent-child relationship; h) where otherwise legally required. If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to third parties

Having read the policies described above, I agree to all professional policies, agree to meet all financial obligations, and agree that this contract replaces any earlier contracts. Additionally I understand that there can be no absolute guarantee of cure in the practice of psychotherapy.

_____ _____

Signature Date

Client Information Statement

The Texas Boards of Examiners of Licensed Psychologists, Marriage and Family Therapists, Licensed Social Workers and Licensed Professional Counselors were established by the legislature to protect the public. In fulfilling its mission, the Boards enacted rules governing the practice of psychology, family therapy, and counseling. These rules require that a therapist provide prospective clients with sufficient information about the therapeutic process so that the client can make an informed decision whether or not to enter therapy.

Attached to this Information Statement is a general information statement, Agreement for Services and the information regarding the procedures or psychotherapy in general and our office policies.

After reading the agreements, please ask about any part of the agreement that you do not understand.

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PERSONAL DATA RECORD

Client Name _____ Date of Birth _____

Address _____

City/State/Zip _____

SSN _____ TXDL _____

Employer/School/Address _____

May we leave a message at any of the following?

Cell phone (circle one)	_____	Yes	No
Work phone (circle one)	_____	Yes	No
Unencrypted email address	_____	Yes	No

*** Please do not cancel appointments via email. You must contact the office directly.**

If you would like to use an address other than your home address for billing and other correspondence, please provide an alternative address below.

Other _____

CONSENT FOR TREATMENT

Client Name _____Date of Birth _____

I give full consent for ***myself, my child/adolescent or dependent*** due to legal guardianship to receive outpatient mental health services until I notify WFI of any changes or until it is determined the treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for the individual stated above.

_____ _____

Authorized Signature Date

REQUIRED: We require that a credit card be provided for after-hours appointments, missed sessions, and late cancellations. You may also designate the use of this card for regularly scheduled sessions.

Cardholder's Name_____ Relationship_____

MC/VISA/DISC No._____ Exp. Date _____

Signature of Authorized User _____

☐ **Use for <u>regular</u> sessions, after hours, missed or late cancel sessions**

Financial Responsibility

Name of person(s) financially responsible for this account _____

Address/phone if different from client _____

_____

_____

Signature(s) _____

Relationship to client _____

Emergency Contact

Name _____ Phone _____

Alternate phone _____ Address_____

_____

Relationship to client _____

Referred to our office by _____

May we send a **thank you** to the person who referred you? _____ (circle one) Yes No

May we mention your **name** in that thank you? (circle one) Yes No

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Appointment Reminders

As a courtesy, you will receive an appointment reminder to your email address or your cell phone (via text message or computer generated voice mail message), the day before your scheduled appointments.

Your name: (Please print): _____

Your email address: _____

Your cell number: _____

Where would you like to receive appointment reminders? (Check one)

_____ Via text message on my cell phone (normal text message rates will apply)

_____ Via email message to the address listed above

_____Via automated voice mail message on my cell phone

****Missed appointment fees will still apply. 24 hour cancellation policy still applies. Please call the office if you need to cancel an appointment.****

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

_____ _____

Signature Date

{Please refer to pages 7-8 of this document}

I acknowledge that I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information and the Office Information and Office Policies.** I understand and accept those policies and practices. WFI is hereby granted consent to contact me as specified above and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

_____ _____

Client or Authorized Representative Signature Date

_____Refuse to Sign _____Unable to Sign (specify reason) _____

_____ _____

Signature of Person Documenting Refusal or Inability to Sign Date

Woodlands Family Institute, P.C.

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Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Josh Parham, LPC may *use* or *disclose* your *protected health information (PHI)* for *treatment*, *payment, and health care operations* purposes with your *general consent*. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations": Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of *treatment* would be when I consult with another health care provider, such as your family physician or a colleague. *Payment* is when I obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within the practice of Josh Parham, LPC such as utilizing information that identifies you.
- *"Disclosure"* applies to activities outside of the practice of Josh Parham, LPC, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation regarding a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (Of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or any local or state law enforcement agency.
- **Abuse of the Elderly and Disabled:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a therapist:** If you report to me any situation that constitutes sexual misconduct by a current or former therapist, then I am required to inform the licensing authority of the offending therapist.
- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to the complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and My Professional Duties

Client's Rights:

- *Right to Request Restrictions*-You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*-You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeking my services. Upon your request, I will send bills or other correspondence to another address.)
- *Right to Inspect and Copy*-You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend*-You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting*-You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of the Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy*-You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

My Professional Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, I am required to abide by the terms currently in effect.
- If I revise the policies and procedures, I will post a current copy in my office. You may request a personal copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at (281) 363-4220 if you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to Josh Parham, LPC at: 1610 Woodstead Court, Suite 420, The Woodlands, Texas, 77380.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice goes into effect 6/1/2010. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice upon request, and it will be posted in the office.

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Please take a moment to complete the Presenting Problems and Symptoms sections of the enclosed treatment plan.

Please sign the last page next to "client".

We will review these together and complete the remainder of the plan in our initial session.

Treatment Plan

Date of first session: _____ Name: _____

Presenting problems:

____Depression _____Anxiety _____Relationship Discord____ Stress _____Alcohol
____Obsessive/Compulsive ____Bereavement ____Parenting _____Sexual ____Psychosis
_____Adjustment Issues ____School/Work Issues ____Other (please describe)

Description:

Symptoms:

___appetite ___sleep ___sadness ___self-esteem ___motivation ___energy
___hygiene ___agitation ___hyper ___worry ___social isolation ___tearful
___racing thoughts ___panic attacks ___obsessive thoughts
___compulsive behaviors ___flat emotions ___concentration ___memory
___weight loss/gain ___confidence ___loneliness ___excessive emotionality
___hallucinations ___delusions ___erratic behavior ___alcohol/drug dependence
___other (please describe)

Description:

Treatment Goals:

1. Reduce frequency and intensity of:

2. Increase frequency and intensity of:

3. Eliminate:

Treatment Plan continued

Treatment Methods and Duration:

___Individual sessions weekly or every two weeks

___Relationship/Family sessions weekly or every two weeks

Diagnostic Impression:

_____
_____
_____

Recommendations of Adjunctive Treatment/Assessment:

Plan review/Revision:

_____ _____

Josh Parham, LPC Client